

A NONSUBSTANTIVE REVISION  
OF STATUTES RELATING TO  
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,  
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,  
AND INSURANCE INDUSTRY PROFESSIONALS

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treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still in the limited provider network or delegated entity.

(d) Contracts between a limited provider network or delegated entity and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

(e) This section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

CHAPTER 1273. POINT-OF-SERVICE PLANS

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1 CHAPTER 1273. POINT-OF-SERVICE PLANS

2 SUBCHAPTER A. BLENDED CONTRACTS

3 Revised Law

4 Sec. 1273.001. DEFINITIONS. In this subchapter:

5 (1) "Blended contract" means a single document,  
6 including a single contract policy, certificate, or evidence of  
7 coverage, that provides a combination of indemnity and health  
8 maintenance organization benefits.

9 (2) "Health maintenance organization" has the meaning  
10 assigned by Section 843.002.

11 (3) "Insurer" means an insurance company,  
12 association, or organization authorized to engage in business in  
13 this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885,  
14 886, 887, 888, 941, 942, or 982.

15 (4) "Point-of-service plan" means an arrangement  
16 under which:

17 (A) an enrollee chooses to obtain benefits or  
18 services through:

19 (i) a health maintenance organization  
20 delivery network, including a limited provider network; or

21 (ii) a non-network delivery system outside  
22 the health maintenance organization delivery network, including a  
23 limited provider network, that is administered under an indemnity  
24 benefit arrangement for the cost of health care services; or

25 (B) indemnity benefits for the cost of health  
26 care services are provided by an insurer or group hospital service  
27 corporation in conjunction with network benefits arranged or  
28 provided by a health maintenance organization. (V.T.I.C. Art.  
29 3.64, Sec. (a).)

30 Source Law

31 Art. 3.64. (a) In this article:

32 (1) "Blended contract" means a single  
33 document, including a single contract policy,  
34 certificate, or evidence of coverage, that provides a  
35 combination of indemnity and health maintenance  
36 organization benefits.

37 (2) "Health maintenance organization" has

1 the meaning assigned by Section 2, Texas Health  
2 Maintenance Organization Act (Article 20A.02, Vernon's  
3 Texas Insurance Code).

4 (3) "Insurance carrier" means an insurance  
5 company, group hospital service corporation,  
6 association, or organization authorized to do business  
7 in this state under this chapter or Chapter 8, 10, 11,  
8 12, 13, 14, 15, 18, 19, 20, or 22 of this code.

9 (4) "Point-of-service plan" means an  
10 arrangement under which:

11 (A) an enrollee may choose to obtain  
12 benefits or services, or both benefits and services,  
13 through either a health maintenance organization  
14 delivery network, including a limited provider  
15 network, or through a non-network delivery system  
16 outside the health maintenance organization's health  
17 care delivery network, including a limited provider  
18 network, and that are administered through an  
19 indemnity benefit arrangement for the cost of health  
20 care services; or

21 (B) indemnity benefits for the cost  
22 of the health care services may be provided by an  
23 insurer or group hospital service corporation in  
24 conjunction with network benefits arranged or provided  
25 by a health maintenance organization.

#### 26 Revisor's Note

27 Section (a)(3), V.T.I.C. Article 3.64, refers to  
28 Chapter 3 of the Insurance Code. The relevant portions  
29 of Chapter 3, relating to authorization of domestic,  
30 foreign, and alien life, health, and accident  
31 insurance companies, are revised in Chapters 841 and  
32 982 of this code. The revised law is drafted  
33 accordingly.

#### 34 Revised Law

35 Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may  
36 contract with a health maintenance organization to provide benefits  
37 under a point-of-service plan, including optional coverage for  
38 out-of-area services or out-of-network care. (V.T.I.C. Art. 3.64,  
39 Sec. (b).)

#### 40 Source Law

41 (b) An insurance carrier may contract with a  
42 health maintenance organization to provide benefits  
43 under a point-of-service plan, including optional  
44 coverage for out-of-area services or out-of-network  
45 care.

#### 46 Revised Law

47 Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance  
48 organization and an insurer may offer a blended contract. The use

1 of a blended contract is limited to point-of-service arrangements  
2 between a health maintenance organization and an insurer.

3 (b) A blended contract delivered, issued, or used in this  
4 state is subject to, and must be filed with the department for  
5 approval as provided by, Chapter 1701 and Section 1271.101.  
6 (V.T.I.C. Art. 3.64, Secs. (c), (d).)

7 Source Law

8 (c) An insurance carrier and a health  
9 maintenance organization may offer a blended contract  
10 if indemnity benefits are combined with health  
11 maintenance organization benefits. The use of a  
12 blended contract is limited to point-of-service  
13 arrangements between an insurance carrier and a health  
14 maintenance organization.

15 (d) A blended contract delivered, issued, or  
16 used in this state is subject to and must be filed with  
17 the department for approval as provided by Article  
18 3.42 of this code and Section 9(a)(5), Texas Health  
19 Maintenance Organization Act (Article 20A.09, Vernon's  
20 Texas Insurance Code).

21 Revisor's Note

22 Section (c), V.T.I.C. Article 3.64, provides in  
23 part that an insurer and a health maintenance  
24 organization may offer a blended contract "if  
25 indemnity benefits are combined with health  
26 maintenance organization benefits." The revised law  
27 omits the quoted language as unnecessary because  
28 "blended contract" is defined by Section (a)(1),  
29 Article 3.64, which is revised as Section 1273.001(1),  
30 as a document that "provides a combination of  
31 indemnity and health maintenance organization  
32 benefits."

33 Revised Law

34 Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING  
35 PROVISIONS. Indemnity benefits and services provided under a  
36 point-of-service plan may be limited to those services described by  
37 the blended contract and may be subject to different cost-sharing  
38 provisions. The cost-sharing provisions for indemnity benefits may  
39 be higher than the cost-sharing provisions for in-network health  
40 maintenance organization coverage. For an enrollee in a limited

1 provider network, higher cost-sharing may be imposed only when the  
2 enrollee obtains benefits or services outside the health  
3 maintenance organization delivery network. (V.T.I.C. Art. 3.64,  
4 Sec. (e).)

5 Source Law

6 (e) Indemnity benefits and services provided  
7 under a point-of-service plan may be limited to those  
8 services as defined by the blended contract and may be  
9 subject to different cost-sharing provisions. The  
10 cost-sharing provisions for the indemnity benefits may  
11 be higher than cost-sharing provisions for in-network  
12 health maintenance organization coverage. For  
13 enrollees in limited provider networks, higher cost  
14 sharing may be imposed only when obtaining benefits or  
15 services outside the health maintenance organization  
16 delivery network.

17 Revised Law

18 Sec. 1273.005. RULES. The commissioner may adopt rules to  
19 implement this subchapter. (V.T.I.C. Art. 3.64, Sec. (f).)

20 Source Law

21 (f) The commissioner may adopt rules to  
22 implement this article.

23 [Sections 1273.006-1273.050 reserved for expansion]

24 SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE

25 OPTIONS

26 Revised Law

27 Sec. 1273.051. DEFINITIONS. In this subchapter:

28 (1) "Employee" means an individual employed by an  
29 employer.

30 (2) "Health benefit plan" has the meaning assigned by  
31 Section 1501.002.

32 (3) "Non-network plan" means health benefit coverage  
33 that provides an enrollee an opportunity to obtain health care  
34 services through a health delivery system other than a health  
35 maintenance organization delivery network, as defined by Section  
36 843.002.

37 (4) "Point-of-service plan" means an arrangement  
38 under which an enrollee chooses to obtain benefits or services  
39 through:

1 (A) a health maintenance organization delivery  
2 network, including a limited provider network; or

3 (B) a non-network delivery system outside the  
4 health maintenance organization delivery network, including a  
5 limited provider network, that is administered under an indemnity  
6 benefit arrangement for the cost of health care services.

7 (5) "Preferred provider benefit plan" means an  
8 insurance policy issued under Chapter 1301.

9 (6) "Small employer health benefit plan" has the  
10 meaning assigned by Section 1501.002. (V.T.I.C. Art. 26.02,  
11 Subdivs. (10), (11), (31), as amended Acts 77th Leg., R.S., Ch. 608,  
12 (32), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.09, Sec.  
13 (a).)

14 Source Law

15 Art. 26.02. In this chapter:

16 (10) "Employee" means any individual  
17 employed by an employer.

18 (11) "Health benefit plan" means a group,  
19 blanket, or franchise insurance policy, a certificate  
20 issued under a group policy, a group hospital service  
21 contract, or a group subscriber contract or evidence  
22 of coverage issued by a health maintenance  
23 organization that provides benefits for health care  
24 services. The term does not include:

25 (A) accident-only or disability  
26 income insurance or a combination of accident-only and  
27 disability income insurance;

28 (B) credit-only insurance;

29 (C) disability insurance coverage;

30 (D) coverage for a specified disease  
31 or illness;

32 (E) Medicare services under a federal  
33 contract;

34 (F) Medicare supplement and Medicare  
35 Select policies regulated in accordance with federal  
36 law;

37 (G) long-term care coverage or  
38 benefits, nursing home care coverage or benefits, home  
39 health care coverage or benefits, community-based care  
40 coverage or benefits, or any combination of those  
41 coverages or benefits;

42 (H) coverage that provides  
43 limited-scope dental or vision benefits;

44 (I) coverage provided by a single  
45 service health maintenance organization;

46 (J) coverage issued as a supplement  
47 to liability insurance;

48 (K) workers' compensation or similar  
49 insurance;

50 (L) automobile medical payment  
51 insurance coverage;

52 (M) jointly managed trusts

1 authorized under 29 U.S.C. Section 141 et seq. that  
2 contain a plan of benefits for employees that is  
3 negotiated in a collective bargaining agreement  
4 governing wages, hours, and working conditions of the  
5 employees that is authorized under 29 U.S.C. Section  
6 157;

7 (N) hospital indemnity or other fixed  
8 indemnity insurance;

9 (O) reinsurance contracts issued on a  
10 stop-loss, quota-share, or similar basis;

11 (P) short-term major medical  
12 contracts;

13 (Q) liability insurance, including  
14 general liability insurance and automobile liability  
15 insurance;

16 (R) other coverage that is:

17 (i) similar to the coverage  
18 described by this subdivision under which benefits for  
19 medical care are secondary or incidental to other  
20 insurance benefits; and

21 (ii) specified in federal  
22 regulations;

23 (S) coverage for on-site medical  
24 clinics; or

25 (T) coverage that provides other  
26 limited benefits specified by federal regulations.

27 (31) "Small employer health benefit plan"  
28 means a plan developed by the commissioner under  
29 Subchapter E of this chapter or any other health  
30 benefit plan offered to a small employer in accordance  
31 with Article 26.42(c) or 26.48 of this code.

32 (32) "Small employer health benefit plan"  
33 means a plan developed by the commissioner under  
34 Subchapter E of this chapter or any other health  
35 benefit plan offered to a small employer in accordance  
36 with Article 26.42(c) or 26.48 of this code.

37 Art. 26.09. (a) In this article:

38 (1) "Non-network plan" means health  
39 benefit coverage that provides an enrollee an  
40 opportunity to obtain health care services through a  
41 health delivery system other than a health maintenance  
42 organization delivery network, as defined by Section  
43 2, Texas Health Maintenance Organization Act (Article  
44 20A.02, Vernon's Texas Insurance Code).

45 (2) "Point-of-service plan" means an  
46 arrangement under which an enrollee may choose to  
47 obtain benefits and services, or both benefits and  
48 services, through either a health maintenance  
49 organization delivery network, including a limited  
50 provider network, or through a non-network delivery  
51 system outside the health maintenance organization's  
52 health care delivery network, including a limited  
53 provider network, and that are administered through an  
54 indemnity benefit arrangement for the cost of health  
55 care services.

56 (3) "Preferred provider benefit plan"  
57 means an insurance policy issued and licensed under  
58 Article 3.70-3C of this code, as added by Chapter 1024,  
59 Acts of the 75th Legislature, Regular Session, 1997.

60 Revisor's Note

61 (1) Subdivision (11), V.T.I.C. Article 26.02,  
62 defines "health benefit plan," and Subdivision (31),



1 V.T.I.C. Article 26.02, as amended by Chapter 608,  
2 Acts of the 77th Legislature, Regular Session, 2001,  
3 and Subdivision (32), V.T.I.C. Article 26.02, as  
4 amended by Chapter 823, Acts of the 77th Legislature,  
5 Regular Session, 2001, define "small employer health  
6 benefit plan." The substance of those definitions is  
7 revised in Section 1501.002, and the revised law  
8 substitutes a cross-reference to that section for the  
9 substance of the definitions.

10 (2) Subsection (a)(3), V.T.I.C. Article 26.09,  
11 defines "preferred provider benefit plan" as an  
12 insurance policy "issued and licensed" under V.T.I.C.  
13 Article 3.70-3C, as added by Chapter 1024, Acts of the  
14 75th Legislature, Regular Session, 1997, revised as  
15 Chapter 1301. The revised law omits the reference to  
16 "licensed" as inaccurate and unnecessary. An  
17 insurance policy is not "licensed" under Article  
18 3.70-3C, and the requirement that the policy be  
19 "issued" under that article is sufficient to ensure  
20 that the policy complies with the requirements of that  
21 article.

#### 22 Revised Law

23 Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN  
24 REQUIRED. (a) Except as provided by Subsection (b), if the only  
25 health benefit coverage offered under an employer's health benefit  
26 plan is a network-based delivery system of coverage offered by one  
27 or more health maintenance organizations, each health maintenance  
28 organization offering coverage must offer to all eligible  
29 employees, at the time of enrollment and at least annually, the  
30 opportunity to obtain coverage through a non-network plan.

31 (b) Each health maintenance organization to which  
32 Subsection (a) applies may enter into an agreement designating one  
33 or more of those health maintenance organizations to offer the  
34 coverage required by Subsection (a) for eligible employees of the

1 employer. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

2 Source Law

3 (b) If the only health benefit coverage offered  
4 under an employer's health benefit plan is a  
5 network-based delivery system of coverage offered by  
6 one or more health maintenance organizations, each  
7 health maintenance organization offering coverage  
8 under the employer's health benefit plan must offer to  
9 all eligible employees the opportunity to obtain  
10 health benefit coverage through a non-network plan at  
11 the time of enrollment and at least annually, unless  
12 all health maintenance organizations offering  
13 coverage under the employer's health benefit plan  
14 enter into an agreement designating one or more of  
15 those health maintenance organizations to offer that  
16 coverage. . . .

17 Revised Law

18 Sec. 1273.053. COVERAGE OPTIONS. The coverage required to  
19 be offered under this subchapter may be provided through:

- 20 (1) a point-of-service plan;  
21 (2) a preferred provider benefit plan; or  
22 (3) any coverage arrangement that provides an enrollee  
23 with access to services outside the health maintenance  
24 organization's or limited provider network's delivery network.  
25 (V.T.I.C. Art. 26.09, Sec. (b) (part).)

26 Source Law

27 (b) . . . The coverage required under this  
28 subsection may be provided through a point-of-service  
29 contract, a preferred provider benefit plan, or any  
30 coverage arrangement that allows an enrollee to access  
31 services outside the health maintenance organization's  
32 or limited provider network's delivery network.

33 Revisor's Note

34 Section (b), V.T.I.C. Article 26.09, refers to a  
35 "point-of-service contract." Throughout this  
36 subchapter, the revised law substitutes  
37 "point-of-service plan" for "point-of-service  
38 contract" because "point-of-service plan" is the term  
39 defined under Section (a)(2), V.T.I.C. Article 26.09,  
40 revised as Section 1273.051(4).

41 Revised Law

42 Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium  
43 for coverage required to be offered under this subchapter must be

1 based on the actuarial value of that coverage and may be different  
2 from the premium for coverage otherwise offered by the health  
3 maintenance organization. (V.T.I.C. Art. 26.09, Sec. (c).)

4 Source Law

5 (c) The premium for coverage required to be  
6 offered under this article shall be based on the  
7 actuarial value of that coverage and may be different  
8 than the premium for the health maintenance  
9 organization coverage.

10 Revised Law

11 Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different  
12 cost-sharing provisions may be imposed for a point-of-service plan  
13 offered under this subchapter, and those provisions may be higher  
14 than the cost-sharing provisions for in-network health maintenance  
15 organization coverage. For an enrollee in a limited provider  
16 network, higher cost-sharing may be imposed only when the enrollee  
17 obtains benefits or services outside the health maintenance  
18 organization delivery network.

19 (b) An employee who chooses the non-network plan is  
20 responsible for any additional costs for the non-network plan, and  
21 the employer may impose a reasonable administrative fee for  
22 providing the non-network plan. (V.T.I.C. Art. 26.09, Secs. (d),  
23 (e).)

24 Source Law

25 (d) Different cost-sharing provisions may be  
26 imposed for a point-of-service contract offered under  
27 this article and may be higher than cost-sharing  
28 provisions for in-network health maintenance  
29 organization coverage. For enrollees in limited  
30 provider networks, higher cost sharing may be imposed  
31 only when obtaining benefits or services outside the  
32 health maintenance organization delivery network.

33 (e) Any additional costs for the non-network  
34 plan are the responsibility of the employee who  
35 chooses the non-network plan, and the employer may  
36 impose a reasonable administrative cost for providing  
37 the non-network plan option.

38 Revised Law

39 Sec. 1273.056. EXCEPTIONS. This subchapter does not apply  
40 to:

- 41 (1) a small employer health benefit plan; or  
42 (2) a group model health maintenance organization that

1 is a nonprofit, state-certified health maintenance organization  
2 that:

3 (A) provides the majority of its professional  
4 services through a single group medical practice that is governed  
5 by a board composed entirely of physicians; and

6 (B) educates medical students or resident  
7 physicians through a contract with the medical school component of  
8 a Texas state-supported college or university accredited by the  
9 Accreditation Council on Graduate Medical Education or the American  
10 Osteopathic Association. (V.T.I.C. Art. 26.09, Sec. (f).)

11 Source Law

12 (f) This article does not apply to:

13 (1) a small employer health benefit plan;  
14 or

15 (2) a group model health maintenance  
16 organization that is a nonprofit, state-certified  
17 health maintenance organization that provides the  
18 majority of its professional services through a single  
19 group medical practice that is governed by a board  
20 composed entirely of physicians and that educates  
21 medical students or resident physicians through a  
22 contract with the medical school component of a Texas  
23 state-supported college or university accredited by  
24 the Accrediting Council on Graduate Medical Education  
25 or the American Osteopathic Association.

26 Revisor's Note

27 Section (f)(2), V.T.I.C. Article 26.09, refers  
28 to the "Accrediting Council on Graduate Medical  
29 Education." The revised law substitutes  
30 "Accreditation Council on Graduate Medical Education"  
31 because that is the proper name of that organization.

32 Revised Law

33 Sec. 1273.057. RULES. The commissioner shall adopt rules  
34 necessary to administer this subchapter. (V.T.I.C. Art. 26.04  
35 (part).)

36 Source Law

37 Art. 26.04. The commissioner shall adopt rules  
38 as necessary to implement this chapter and . . . .

39 [Chapters 1274-1300 reserved for expansion]

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15                   SUBCHAPTER A.    GENERAL PROVISIONS

16                                    Revised Law

17                   Sec. 1301.001.    DEFINITIONS.    In this chapter:

18                                    (1) "Health care provider" means a practitioner,

19                   institutional provider, or other person or organization that

20                   furnishes health care services and that is licensed or otherwise

21                   authorized to practice in this state. The term does not include a

22                   physician.

23                                    (2) "Health insurance policy" means a group or

24                   individual insurance policy, certificate, or contract providing

25                   benefits for medical or surgical expenses incurred as a result of an

26                   accident or sickness.

27                                    (3) "Hospital" means a licensed public or private

28                   institution as defined by Chapter 241, Health and Safety Code, or

29                   Subtitle C, Title 7, Health and Safety Code.

30                                    (4) "Institutional provider" means a hospital,

31                   nursing home, or other medical or health-related service facility

32                   that provides care for the sick or injured or other care that may be

33                   covered in a health insurance policy.

34                                    (5) "Insurer" means a life, health, and accident

1 insurance company, health and accident insurance company, health  
2 insurance company, or other company operating under Chapter 841,  
3 842, 884, 885, 982, or 1501, that is authorized to issue, deliver,  
4 or issue for delivery in this state health insurance policies.

5 (6) "Physician" means a person licensed to practice  
6 medicine in this state.

7 (7) "Practitioner" means a person who practices a  
8 healing art and is a practitioner described by Section 1451.001 or  
9 1451.101.

10 (8) "Preferred provider" means a physician or health  
11 care provider, or an organization of physicians or health care  
12 providers, who contracts with an insurer to provide medical care or  
13 health care to insureds covered by a health insurance policy.

14 (9) "Preferred provider benefit plan" means a benefit  
15 plan in which an insurer provides, through its health insurance  
16 policy, for the payment of a level of coverage that is different  
17 from the basic level of coverage provided by the health insurance  
18 policy if the insured person uses a preferred provider.

19 (10) "Service area" means a geographic area or areas  
20 specified in a health insurance policy or preferred provider  
21 contract in which a network of preferred providers is offered and  
22 available. (V.T.I.C. Art. 3.70-3C, Secs. 1(2), (3), (4), (5), (6),  
23 (8), (9), (10), (13), 2 (part), as added Acts 75th Leg., R.S., Ch.  
24 1024; Art. 3.70-3C, Sec. 1, as added Acts 75th Leg., R.S., Ch.  
25 1260.)

26 Source Law

27 [Art. 3.70-3C, as added Acts 75th Leg., R.S., Ch.  
28 1024]

29 (2) "Health insurance policy" means a  
30 group or individual insurance policy, certificate, or  
31 contract providing benefits for medical or surgical  
32 expenses incurred as a result of an accident or  
33 sickness.

34 (3) "Health care provider" or "provider"  
35 means any practitioner, institutional provider, or  
36 other person or organization that furnishes health  
37 care services and that is licensed or otherwise  
38 authorized to practice in this state, other than a  
39 physician.

40 (4) "Hospital" means a licensed public or  
41 private institution as defined in Chapter 241, Health



1 and Safety Code, or in Subtitle C, Title 7, Health and  
2 Safety Code.

3 (5) "Institutional provider" means a  
4 hospital, nursing home, or any other medical or  
5 health-related service facility caring for the sick or  
6 injured or providing care for other coverage which may  
7 be provided in a health insurance policy.

8 (6) "Insurer" means any life, health, and  
9 accident; health and accident; or health insurance  
10 company or company operating pursuant to Chapter 3,  
11 10, 20, 22, or 26 of this code authorized to issue,  
12 deliver, or issue for delivery in this state health  
13 insurance policies, certificates, or contracts.

14 (8) "Physician" means anyone licensed to  
15 practice medicine in the State of Texas.

16 (9) "Practitioner" means a person who  
17 practices a healing art and is a practitioner  
18 described by:

19 (A) Section 2(B), Chapter 397, Acts  
20 of the 54th Legislature, 1955 (Article 3.70-2,  
21 Vernon's Texas Insurance Code); or

22 (B) Article 21.52 of this code.

23 (10) "Preferred provider" means a  
24 physician, practitioner, hospital, institutional  
25 provider, or health care provider, or an organization  
26 of physicians or health care providers, who contracts  
27 with an insurer to provide medical care or health care  
28 to insureds covered by a health insurance policy,  
29 certificate, or contract.

30 (13) "Service area" means a geographic  
31 area or areas set forth in the health insurance policy  
32 or preferred provider contract in which a network of  
33 preferred providers is offered and available.

34 Sec. 2. This article applies to any preferred  
35 provider benefit plan in which an insurer provides,  
36 through its health insurance policy, for the payment  
37 of a level of coverage which is different from the  
38 basic level of coverage provided by the health  
39 insurance policy if the insured uses a preferred  
40 provider. . . .

41 Art. 3.70-3C [as added Acts 75th Leg., R.S., Ch.  
42 1260]

43 Sec. 1. In this article:

44 (1) "Preferred provider" means a  
45 physician, advanced practice nurse, physician  
46 assistant, or other health care provider, or an  
47 organization of physicians or health care providers,  
48 who contracts with an insurer to provide medical care  
49 or health care to insureds covered by a health  
50 insurance policy, certificate, or contract.

51 (2) "Preferred provider benefit plan"  
52 means a benefit plan through which an insurer  
53 provides, through its health insurance policy, for the  
54 payment of a level of coverage that is different from  
55 the basic level of coverage provided by the health  
56 insurance policy if the insured uses a preferred  
57 provider.

58 Revisor's Note

59 (1) Section 1(6), V.T.I.C. Article 3.70-3C, as  
60 added by Chapter 1024, Acts of the 75th Legislature,  
61 Regular Session, 1997, refers to Chapter 3 of the

1 Insurance Code. The pertinent portions of Chapter 3,  
2 relating to organization of entities that may write  
3 health insurance policies, are revised in Chapters 841  
4 and 982 of this code. The revised law is drafted  
5 accordingly.

6 (2) Section 1(10), V.T.I.C. Article 3.70-3C, as  
7 added by Chapter 1024, Acts of the 75th Legislature,  
8 Regular Session, 1997, in part defines "preferred  
9 provider" as a "physician, practitioner, hospital,  
10 institutional provider, or health care provider." The  
11 revised law omits the references to "practitioner,"  
12 "hospital," and "institutional provider" because each  
13 of those entities is explicitly listed or clearly  
14 included within the meaning of "health care provider"  
15 under Section 1(3) of Article 3.70-3C.

16 (3) Section 1(1), V.T.I.C. Article 3.70-3C, as  
17 added by Chapter 1260, Acts of the 75th Legislature,  
18 Regular Session, 1997, in part defines "preferred  
19 provider" as a "physician, advanced practice nurse,  
20 physician assistant, or other health care provider."  
21 The revised law omits the references to "advanced  
22 practice nurse" and "physician assistant" because each  
23 of those entities is a practitioner described by  
24 Section 2(B), Chapter 397, Acts of the 54th  
25 Legislature, Regular Session, 1955 (Article 3.70-2,  
26 Vernon's Texas Insurance Code), revised as Section  
27 1451.001 of this code. As such, each of those entities  
28 is included within the meaning of "health care  
29 provider" under Section 1(3), V.T.I.C. Article  
30 3.70-3C, as added by Chapter 1024, Acts of the 75th  
31 Legislature, Regular Session, 1997, and the revised  
32 law definition of "preferred provider" specifically  
33 lists health care providers.

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Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS. This chapter does not apply to a provision for dental care benefits in a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 2 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 2. . . . This article does not apply to provisions for dental care benefits in any health insurance policy.

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS  
PERMITTED. A health insurance policy that provides different  
benefits from the basic level of coverage for the use of preferred  
providers and that meets the requirements of this chapter is not:

- (1) unjust under Chapter 1701;
  - (2) unfair discrimination under Subchapter A or B, Chapter 544; or
  - (3) a violation of Subchapter B or C, Chapter 1451.
- (V.T.I.C. Art. 3.70-3C, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 3. (a) A health insurance policy that includes different benefits from the basic level of coverage for the use of preferred providers shall not be considered unjust under Article 3.42 of this code, or unfair discrimination under Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, 1995, or Article 21.21-8 of this code or to violate Subsection (B), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), or Article 21.52 of this code, if it meets the requirements of this section.

Section 3(a), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, provides that a health insurance policy establishing a preferred provider benefit plan does not violate certain provisions of law relating to unjust policy provisions, unfair discrimination, and selection of practitioners if the policy meets the

1 requirements of "this section," meaning Section 3,  
2 Article 3.70-3C. However, the portion of Section 3  
3 revised as Section 1301.004 requires a preferred  
4 provider benefit plan to comply with "this article,"  
5 meaning all of Article 3.70-3C. Accordingly, the  
6 revised law refers to this chapter, rather than the  
7 portions of this chapter that were derived from  
8 Section 3, Article 3.70-3C.

9 Revised Law

10 Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED. Each  
11 preferred provider benefit plan offered in this state must comply  
12 with this chapter. (V.T.I.C. Art. 3.70-3C, Sec. 3(1) (part), as  
13 added Acts 75th Leg., R.S., Ch. 1024.)

14 Source Law

15 (1) . . . All preferred provider insurance  
16 benefit plans offered in this state shall comply with  
17 the requirements of this article.

18 Revised Law

19 Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a)  
20 An insurer offering a preferred provider benefit plan shall ensure  
21 that both preferred provider benefits and basic level benefits are  
22 reasonably available to all insureds within a designated service  
23 area.

24 (b) If services are not available through a preferred  
25 provider within the service area, an insurer shall reimburse a  
26 physician or health care provider who is not a preferred provider at  
27 the same percentage level of reimbursement as a preferred provider  
28 would have been reimbursed had the insured been treated by a  
29 preferred provider.

30 (c) Subsection (b) does not require reimbursement at a  
31 preferred level of coverage solely because an insured resides out  
32 of the service area and chooses to receive services from a provider  
33 other than a preferred provider for the insured's own convenience.  
34 (V.T.I.C. Art. 3.70-3C, Sec. 8, as added Acts 75th Leg., R.S., Ch.  
35 1024.)

### Source Law

Sec. 8. (a) Any insurer offering a preferred provider benefit plan must ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) If services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as the preferred providers would have been reimbursed had the insured been treated by them. Nothing in this subsection requires reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience.

Revised Law

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. (V.T.I.C. Art. 3.70-3C, Sec. 3(d), as added Acts 75th Leg., R.S., Ch. 1024.)

## Source Law

(d) Insurers which market a preferred provider benefit plan must contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner assuring both availability and accessibility of adequate personnel, specialty care, and facilities.

## Revised Law

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to:

- (1) implement this chapter; and
- (2) ensure reasonable accessibility and availability of preferred provider benefits and basic level benefits to residents of this state. (V.T.I.C. Art. 3.70-3C, Sec. 9, as added

1 Acts 75th Leg., R.S., Ch. 1024.)

2 Source Law

3 Sec. 9. The commissioner shall adopt rules as  
4 necessary to implement the provisions of this article  
5 and to ensure reasonable accessibility and  
6 availability of preferred provider and basic level  
7 benefits to Texas citizens.

8 Revisor's Note

9 Section 9, V.T.I.C. Article 3.70-3C, refers to  
10 "Texas citizens." The revised law substitutes  
11 "residents" for "citizens" because, in the context of  
12 this section, "citizen" and "resident" are synonymous,  
13 and "resident" is more commonly used.

14 [Sections 1301.008-1301.050 reserved for expansion]

15 SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR  
16 HEALTH CARE PROVIDERS

17 Revised Law

18 Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An  
19 insurer shall afford a fair, reasonable, and equivalent opportunity  
20 to apply to be and to be designated as a preferred provider to  
21 practitioners and institutional providers and to health care  
22 providers other than practitioners and institutional providers, if  
23 those other health care providers are included by the insurer as  
24 preferred providers, provided that the practitioners,  
25 institutional providers, or health care providers:

26 (1) are licensed to treat injuries or illnesses or to  
27 provide services covered by a health insurance policy; and

28 (2) comply with the terms established by the insurer  
29 for designation as preferred providers.

30 (b) An insurer may not unreasonably withhold a designation  
31 as a preferred provider.

32 (c) An insurer shall give a physician or health care  
33 provider who, on the person's initial application, is not  
34 designated as a preferred provider written reasons for denial of  
35 the designation.

36 (d) Unless otherwise limited by this code, this section does

1 not prohibit an insurer from rejecting a physician's or health care  
2 provider's application for designation based on a determination  
3 that the preferred provider benefit plan has sufficient qualified  
4 providers. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(1), (4), as added  
5 Acts 75th Leg., R.S., Ch. 1024.)

6 Source Law

7 (b)(1) Physicians, practitioners, institutional  
8 providers, and health care providers other than  
9 physicians, practitioners, and institutional  
10 providers, if such other health care providers are  
11 included by the insurer as preferred providers,  
12 licensed to treat injuries or illnesses or to provide  
13 services covered by the health insurance policy that  
14 comply with the terms and conditions established by  
15 the insurer for designation as preferred providers may  
16 apply for and shall be afforded a fair, reasonable, and  
17 equivalent opportunity to become preferred providers.  
18 Such designation shall not be unreasonably withheld.

19 (4) The insurer must give a physician or  
20 health care provider not designated on initial  
21 application written reasons for denial of the  
22 designation; however, unless otherwise limited by  
23 this code, this section does not prohibit an insurer  
24 from rejecting an application from a physician or  
25 health care provider based on a determination that the  
26 preferred provider benefit plan has sufficient  
27 qualified providers.

28 Revisor's Note

29 (1) Section 3(b)(1), V.T.I.C. Article 3.70-3C,  
30 as added by Chapter 1024, Acts of the 75th Legislature,  
31 Regular Session, 1997, refers to "physicians [and]  
32 practitioners"; similar phrases appear in subsequent  
33 sections of Article 3.70-3C. Throughout this chapter,  
34 the revised law omits such references to a "physician"  
35 as unnecessary. Section 1(9), Article 3.70-3C, in  
36 part defines "practitioner" as a person described as a  
37 practitioner under Section 2(B), Chapter 397, Acts of  
38 the 54th Legislature, Regular Session, 1955 (Article  
39 3.70-2, Vernon's Texas Insurance Code). That section,  
40 which is revised in relevant part as Section 1451.001,  
41 describes a "Doctor of Medicine" licensed in Texas as a  
42 practitioner. "Doctor of Medicine" and "physician"  
43 are synonymous under Section 104.003(b), Occupations

1 Code.

2 (2) Section 3(b)(1), V.T.I.C. Article 3.70-3C,  
3 as added by Chapter 1024, Acts of the 75th Legislature,  
4 Regular Session, 1997, refers to the "terms and  
5 conditions" established by an insurer for designation  
6 as a preferred provider; subsequent sections also use  
7 that phrase. Throughout this chapter, the revised law  
8 omits references to a "condition" because "condition"  
9 is included within the meaning of "term."

10 Revised Law

11 Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR  
12 PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a  
13 preferred provider benefit plan may not refuse a request made by a  
14 physician participating as a preferred provider under the plan and  
15 an advanced practice nurse or physician assistant to have the  
16 advanced practice nurse or physician assistant included as a  
17 preferred provider under the plan if:

18 (1) the advanced practice nurse or physician assistant  
19 is authorized by the physician to provide care under Subchapter B,  
20 Chapter 157, Occupations Code; and

21 (2) the advanced practice nurse or physician assistant  
22 meets the quality of care standards previously established by the  
23 insurer for participation in the plan by advanced practice nurses  
24 and physician assistants. (V.T.I.C. Art. 3.70-3C, Sec. 2, as added  
25 Acts 75th Leg., R.S., Ch. 1260.)

26 Source Law

27 Sec. 2. If an advanced practice nurse or  
28 physician assistant is authorized to provide care  
29 under Section 3.06(d)(5) or (6), Medical Practice Act  
30 (Article 4495b, Vernon's Texas Civil Statutes), by a  
31 physician participating as a preferred provider under  
32 a preferred provider benefit plan, that plan may not  
33 refuse a request made by the physician and physician  
34 assistant or advanced practice nurse to have the  
35 physician assistant or advanced practice nurse  
36 included as a preferred provider by the plan unless the  
37 physician assistant or advanced practice nurse fails  
38 to meet the quality of care standards previously  
39 established by the preferred provider benefit plan for  
40 participation in the plan by advanced practice nurses  
41 and physician assistants.



1 Revisor's Note

2 (1) Section 2, V.T.I.C. Article 3.70-3C, as  
3 added by Chapter 1260, Acts of the 75th Legislature,  
4 Regular Session, 1997, refers to Sections 3.06(d)(5)  
5 and (6), Medical Practice Act (Article 4495b, Vernon's  
6 Texas Civil Statutes). Those statutes were codified  
7 in 1999 as Subchapter B, Chapter 157, Occupations  
8 Code. The revised law is drafted accordingly.

9 (2) Section 3, V.T.I.C. Article 3.70-3C, as  
10 added by Chapter 1260, Acts of the 75th Legislature,  
11 Regular Session, 1997, prohibits a preferred provider  
12 benefit plan from taking certain action in relation to  
13 an advanced practice nurse or physician assistant  
14 because those practitioners are "not identified under  
15 Section 3, Article 21.52, Insurance Code." However,  
16 Chapter 428, Acts of the 76th Legislature, Regular  
17 Session, 1999, subsequently added those practitioners  
18 to Section 3, Article 21.52, and thus impliedly  
19 repealed Section 3, V.T.I.C. Article 3.70-3C.  
20 Therefore, the revised law omits Section 3, V.T.I.C.  
21 Article 3.70-3C. The omitted law reads:

22 Sec. 3. A preferred provider benefit  
23 plan may not refuse to contract with an  
24 advanced practice nurse or physician  
25 assistant to be included in the plan's  
26 provider network, refuse to reimburse the  
27 advanced practice nurse or physician  
28 assistant for covered services, or  
29 otherwise discriminate against the advanced  
30 practice nurse or physician assistant  
31 because the advanced practice nurse or  
32 physician assistant is not identified under  
33 Section 3, Article 21.52, Insurance Code.

34 Revised Law

35 Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED  
36 PROVIDER. (a) An insurer that does not designate a practitioner  
37 as a preferred provider shall provide a reasonable mechanism for  
38 reviewing that action. The review mechanism must incorporate, in  
39 an advisory role only, a review panel.

1 (b) A review panel must be composed of at least three  
2 individuals selected by the insurer from a list of participating  
3 practitioners and must include one member who is a practitioner in  
4 the same or similar specialty as the affected practitioner, if  
5 available. The practitioners contracting with the insurer in the  
6 applicable service area shall provide the list of practitioners to  
7 the insurer.

8 (c) On request, the insurer shall provide to the affected  
9 practitioner:

- 10 (1) the panel's recommendation, if any; and  
11 (2) a written explanation of the insurer's  
12 determination, if that determination is contrary to the panel's  
13 recommendation. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(2), (3), as  
14 added Acts 75th Leg., R.S., Ch. 1024.)

15 Source Law

16 (2) If a designation as a preferred  
17 provider is withheld relating to a physician or  
18 practitioner, the insurer shall provide a reasonable  
19 review mechanism that incorporates, in an advisory  
20 role only, a review panel. Any recommendation of the  
21 panel shall be provided on request to the affected  
22 physician or practitioner. In the event of an insurer  
23 determination contrary to any recommendation of the  
24 panel, a written explanation of the insurer's  
25 determination shall also be provided on request to the  
26 affected physician or practitioner.

27 (3) The review panel shall be composed of  
28 not less than three individuals selected by the  
29 insurer from a list of the physicians or practitioners  
30 contracting with the insurer and shall include one  
31 member who is a physician or practitioner in the same  
32 or similar specialty as the affected physician or  
33 practitioner, if available. The list of physicians or  
34 practitioners is to be provided to the insurer by the  
35 physicians or practitioners contracting with the  
36 insurer in the applicable service area.

37 Revised Law

38 Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED  
39 PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider  
40 benefit plan, an insurer shall immediately notify each practitioner  
41 in the plan's service area of the insurer's intent to offer the plan  
42 and of the opportunity to participate. The notification must be  
43 made by publication or in writing to each practitioner.

44 (b) After establishing a preferred provider benefit plan,

1 an insurer shall annually provide notice of and an opportunity to  
2 participate in the plan to practitioners in the plan's service area  
3 who do not participate in the plan.

4 (c) On request, an insurer shall provide to any physician or  
5 health care provider information concerning the application  
6 process and qualification requirements for participation as a  
7 preferred provider in the plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(c),  
8 as added Acts 75th Leg., R.S., Ch. 1024.)

9 Source Law

10 (c) Any insurer, when sponsoring a preferred  
11 provider benefit plan, shall immediately notify, by  
12 publication or in writing to each physician and  
13 practitioner, all physicians and practitioners in the  
14 geographic area covered by the plan of its intent to  
15 offer such a plan and of the opportunity to  
16 participate. Such notice and opportunity shall be  
17 provided on a yearly basis thereafter to  
18 noncontracting physicians and practitioners in the  
19 geographic area covered by the plan. The insurer shall  
20 on request make available to any physician or health  
21 care provider information concerning the application  
22 process and qualification requirements for  
23 participation as a provider in the plan.

24 Revisor's Note

25 Section 3(c), V.T.I.C. Article 3.70-3C, as added  
26 by Chapter 1024, Acts of the 75th Legislature, Regular  
27 Session, 1997, refers to "the geographic area covered  
28 by the plan." The revised law substitutes "the plan's  
29 service area" for the quoted language because "service  
30 area" is the defined term under Section 1(13), Article  
31 3.70-3C, as added by Chapter 1024, Acts of the 75th  
32 Legislature, Regular Session, 1997, revised as Section  
33 1301.001(10).

34 Revised Law

35 Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract  
36 under a preferred provider benefit plan between an insurer and a  
37 physician or other practitioner or a physicians' group must have a  
38 mechanism for resolving complaints initiated by an insured, a  
39 physician or other practitioner, or a physicians' group.

40 (b) A complaint resolution mechanism must provide for

1 reasonable due process that includes, in an advisory role only, a  
2 review panel selected in the manner described by Section  
3 1301.053(b). (V.T.I.C. Art. 3.70-3C, Sec. 3(f), as added Acts 75th  
4 Leg., R.S., Ch. 1024.)

5 Source Law

6 (f) Every contract by an insurer with a  
7 physician, physicians group, or practitioner shall  
8 have a mechanism for the resolution of complaints  
9 initiated by the insured, physicians, physicians  
10 groups, or practitioners. Such mechanism shall  
11 provide for reasonable due process which includes, in  
12 an advisory role only, a review panel selected in the  
13 manner described in Subsection (b)(3) of this section.

14 Revised Law

15 Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT.

16 (a) An insurer or third-party administrator may not reimburse a  
17 physician or other practitioner, institutional provider, or  
18 organization of physicians and health care providers on a  
19 discounted fee basis for covered services that are provided to an  
20 insured unless:

21 (1) the insurer or third-party administrator has  
22 contracted with either:

23 (A) the physician or other practitioner,  
24 institutional provider, or organization of physicians and health  
25 care providers; or

26 (B) a preferred provider organization that has a  
27 network of preferred providers and that has contracted with the  
28 physician or other practitioner, institutional provider, or  
29 organization of physicians and health care providers;

30 (2) the physician or other practitioner,  
31 institutional provider, or organization of physicians and health  
32 care providers has agreed to the contract and has agreed to provide  
33 health care services under the terms of the contract; and

34 (3) the insurer or third-party administrator has  
35 agreed to provide coverage for those health care services under the  
36 health insurance policy.

37 (b) A party to a preferred provider contract, including a

1 contract with a preferred provider organization, may not sell,  
2 lease, or otherwise transfer information regarding the payment or  
3 reimbursement terms of the contract without the express authority  
4 of and prior adequate notification to the other contracting  
5 parties. This subsection does not affect the authority of the  
6 commissioner or the Texas Workers' Compensation Commission under  
7 this code to request and obtain information.

8 (c) An insurer or third-party administrator who violates  
9 this section:

10 (1) commits an unfair claim settlement practice in  
11 violation of Subchapter A, Chapter 542; and

12 (2) is subject to administrative penalties under  
13 Chapters 82 and 84. (V.T.I.C. Art. 3.70-3C, Sec. 7A, as added Acts  
14 75th Leg., R.S., Ch. 1024.)

15 Source Law

16 Sec. 7A. (a) An insurer or third party  
17 administrator may not reimburse a physician,  
18 practitioner, hospital, institutional provider, or  
19 organization of physicians and health care providers  
20 on a discounted fee basis for covered services that are  
21 provided to an insured unless:

22 (1) the insurer or third party  
23 administrator has contracted with either:

24 (A) the physician, practitioner,  
25 hospital, institutional provider, organization of  
26 physicians and health care providers; or

27 (B) a preferred provider  
28 organization that has a network of preferred providers  
29 and such organization has contracted with the health  
30 care preferred provider;

31 (2) the physician, practitioner,  
32 hospital, institutional provider, or organization of  
33 physicians and health care providers has agreed to the  
34 contract and has agreed to provide health care  
35 services under the terms of the contract; and

36 (3) the insurer or third party  
37 administrator has agreed to provide coverage for those  
38 health care services under the health insurance  
39 policy.

40 (b) A party to a preferred provider contract,  
41 including a contract with a preferred provider  
42 organization, may not sell, lease, or otherwise  
43 transfer information regarding the payment or  
44 reimbursement terms of the contract without the  
45 express authority and prior adequate notification of  
46 the other contracting parties. This subsection does  
47 not affect the authority of the commissioner or the  
48 Texas Workers' Compensation Commission under this code  
49 to request and obtain information.

50 (c) An insurer or third party administrator who  
51 violates this section commits an unfair claim  
52 settlement practice in violation of Article 21.21-2 of

1       this code and is also subject to administrative  
2       penalties under Articles 1.10 and 1.10E of this code.

3                               Revisor's Note

4               Section 7A(a), V.T.I.C. Article 3.70-3C, as added  
5       by Chapter 1024, Acts of the 75th Legislature, Regular  
6       Session, 1997, refers to a "hospital [or]  
7       institutional provider." The revised law omits the  
8       reference to "hospital" because "hospital" is included  
9       within the meaning of "institutional provider" under  
10      Section 1(5), V.T.I.C. Article 3.70-3C, as added by  
11      Chapter 1024, Acts of the 75th Legislature, Regular  
12      Session, 1997, revised as Section 1301.001(4).

13                              Revised Law

14      Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED  
15      REVIEW PROCESS. (a) Before terminating a contract with a  
16      preferred provider, an insurer shall:

17               (1) provide written reasons for the termination; and

18               (2) if the affected provider is a practitioner,  
19      provide, on request, a reasonable review mechanism, except in a  
20      case involving:

21                       (A) imminent harm to a patient's health;

22                       (B) an action by a state medical or other  
23      physician licensing board or other government agency that  
24      effectively impairs the practitioner's ability to practice  
25      medicine; or

26                       (C) fraud or malfeasance.

27               (b) The review mechanism described by Subsection (a)(2)  
28      must incorporate, in an advisory role only, a review panel selected  
29      in the manner described by Section 1301.053(b) and must be  
30      completed within a period not to exceed 60 days.

31               (c) The insurer shall provide to the affected practitioner:

32                       (1) the panel's recommendation, if any; and

33                       (2) on request, a written explanation of the insurer's  
34      determination, if that determination is contrary to the panel's  
35      recommendation.

(d) On request, an insurer shall make an expedited review available to a practitioner whose participation in a preferred provider benefit plan is being terminated. The expedited review process must comply with rules established by the commissioner. (V.T.I.C. Art. 3.70-3C, Sec. 3(g), as added Acts 75th Leg., R.S., Ch. 1024.)

#### Source Law

(g) Before terminating a contract with a preferred provider, the insurer shall provide written reasons for the termination. Prior to termination of a physician or practitioner, but within a period not to exceed 60 days, the insurer shall, on request, provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel selected in the manner described in Subsection (b)(3) of this section, except in cases in which there is imminent harm to a patient's health or an action by a state medical or other physician licensing board or other government agency that effectively impairs a physician's or practitioner's ability to practice medicine or in cases of fraud or malfeasance. Any recommendation of the panel shall be provided to the affected physician or practitioner. In the event of an insurer determination contrary to any recommendation of the panel, a written explanation of the insurer's determination shall also be provided on request to the affected physician or practitioner. On request, an expedited review process shall be made available to a physician or practitioner who is being terminated. The expedited review process shall comply with rules established by the commissioner.

#### Revised Law

Sec. 1301.058. ECONOMIC PROFILING. An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs. (V.T.I.C. Art. 3.70-3C, Sec. 3(h), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(h) An insurer that conducts, uses, or relies on economic profiling to admit or terminate physicians or health care providers shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

## Revised Law

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer. (V.T.I.C. Art. 3.70-3C, Secs. 1(12), 3(i), as added Acts 75th Leg., R.S., Ch. 1024.)

## Source Law

[Sec. 1]

(12) "Quality assessment" means a mechanism which is in place or put into place and utilized by an insurer for the purposes of evaluating, monitoring, or improving the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with that delivered by an ordinary, reasonable, prudent physician or health care provider under the same or similar circumstances.

[Sec. 3]

(i) No insurer shall engage in quality assessment except through a panel of not less than three physicians selected by the insurer from among a list of physicians contracting with the insurer, which list is to be provided by the physicians contracting with the insurer in the applicable service area.



Revised Law

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge. (V.T.I.C. Art. 3.70-3C, Sec. 3(k), as added Acts 75th Leg., R.S., Ch. 1024.)

## Source Law

(k) A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge.

## Revised Law

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that either the insurer or the preferred provider organization on the insurer's behalf will comply with the notice requirements and other requirements imposed on the insurer by this subchapter.

(b) An insurer that enters into an agreement with a preferred provider organization under this section shall meet the requirements of this chapter or ensure that those requirements are met. (V.T.I.C. Art. 3.70-3C, Sec. 3(1) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

## Source Law

(1) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that the notice and other insurer requirements of this section may be complied with by either the insurer or the preferred provider organization on the insurer's behalf. If an insurer enters into an agreement with a preferred provider organization under this section, it is the insurer's responsibility to meet the requirements of this article or to assure that the requirements are met. . . .

Revised Law

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS AND PODIATRISTS. A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;

(3) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(4) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3(n), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(n) A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request, and the insurer shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(3) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

## Revised Law

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

1 (2) returns the care of the patient to that other  
2 physician at the end of the patient's hospitalization.

3 (b) A preferred provider contract between an insurer and a  
4 physician may not require the physician to use a hospitalist for a  
5 hospitalized patient. (V.T.I.C. Art. 3.70-3C, Sec. 3B, as added  
6 Acts 75th Leg., R.S., Ch. 1024.)

7 Source Law

8 Sec. 3B. (a) In this section, "hospitalist"  
9 means a physician who:

10 (1) serves as physician of record at a  
11 hospital for a hospitalized patient of another  
12 physician; and

13 (2) returns the care of the patient to that  
14 other physician at the end of the patient's  
15 hospitalization.

16 (b) A preferred provider contract between an  
17 insurer and a physician may not require the physician  
18 to use a hospitalist for a hospitalized patient.

19 Revised Law

20 Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF  
21 CLAIMS. Subject to Subchapter C, a preferred provider contract  
22 must provide for payment to a physician or health care provider for  
23 health care services and benefits provided to an insured under the  
24 contract and to which the insured is entitled under the terms of the  
25 contract not later than:

26 (1) the 45th day after the date on which a claim for  
27 payment is received with the documentation reasonably necessary to  
28 process the claim; or

29 (2) if applicable, within the number of calendar days  
30 specified by written agreement between the physician or health care  
31 provider and the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 3(m)  
32 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

33 Source Law

34 (m) . . . A preferred provider contract must  
35 include a provision for payment to the physician or  
36 health care provider for covered services that are  
37 rendered to insureds under the contract not later than  
38 the 45th day after the date on which a claim for  
39 payment is received with the documentation reasonably  
40 necessary to process the claim or, if applicable,  
41 within the number of calendar days specified by  
42 written agreement between the physician or health care  
43 provider and the insurer. For purposes of this  
44 subsection, "covered services" means health care

1 services and benefits to which an insured is entitled  
2 under the terms of the contract.

3 Revisor's Note

4 Section 3(m), V.T.I.C. Article 3.70-3C, as added  
5 by Chapter 1024, Acts of the 75th Legislature, Regular  
6 Session, 1997, prescribes certain provisions relating  
7 to payment for covered services that must be contained  
8 in a contract between an insurer and a preferred  
9 provider. Article 3.70-3C, as added by Chapter 1024,  
10 Acts of the 75th Legislature, Regular Session, 1997,  
11 was amended by the addition of Section 3A by Chapter  
12 1343, Acts of the 76th Legislature, Regular Session,  
13 1999. Section 3A, which is revised as Subchapter C of  
14 this chapter, provides for payment of certain "clean  
15 claims" submitted by a preferred provider. Section  
16 312.014(a), Government Code, provides that "[i]f  
17 statutes enacted at . . . different sessions of the  
18 legislature are irreconcilable, the statute latest in  
19 date of enactment prevails." Thus, as the later  
20 enactment, Section 3A prevails over Section 3(m) to  
21 the extent of any conflict. Accordingly, the revised  
22 law includes a reference to Subchapter C.

23 Revised Law

24 Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY  
25 PROHIBITED. A preferred provider contract may not require any  
26 physician, health care provider, or physicians' group to execute a  
27 hold harmless clause to shift the insurer's tort liability  
28 resulting from the insurer's acts or omissions to the preferred  
29 provider. (V.T.I.C. Art. 3.70-3C, Sec. 3(j), as added Acts 75th  
30 Leg., R.S., Ch. 1024.)

31 Source Law

32 (j) A preferred provider contract may not  
33 require any health care provider, physician, or  
34 physicians group to execute hold harmless clauses in  
35 order to shift the insurer's tort liability resulting  
36 from acts or omissions of the insurer to the preferred  
37 provider.

Revised Law

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. An insurer may not engage in any retaliatory action against a physician or health care provider, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract, because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(b), as added Acts 75th Leg., R.S., Ch. 1024.)

## Source Law

(b) No insurer shall engage in any retaliatory action against a physician or health care provider, including termination of or refusal to renew a contract, because the physician or provider has, on behalf of an insured, reasonably filed a complaint against the insurer or has appealed a decision of the insurer.

Revised Law

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An insurer may not, as a condition of a preferred provider contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a person designated by a patient, information or an opinion:

(1) regarding the patient's health care, including the patient's medical condition or treatment options; or

(2) in good faith regarding the provisions, terms, requirements, or services of the health insurance policy as they relate to the patient's medical needs.

(b) An insurer may not in any way penalize, terminate the participation of, or refuse to compensate for covered services a physician or health care provider for discussing or communicating with a current, prospective, or former patient, or a person

1 designated by a patient, pursuant to this section. (V.T.I.C.  
2 Art. 3.70-3C, Sec. 7(c), as added Acts 75th Leg., R.S., Ch. 1024.)

3 Source Law

4 (c)(1) An insurer shall not, as a condition of a  
5 contract with a physician or health care provider or in  
6 any other manner, prohibit, attempt to prohibit, or  
7 discourage a physician or provider from:

8 (A) discussing with or communicating  
9 to a current, prospective, or former patient, or a  
10 party designated by a patient, information or opinions  
11 regarding that patient's health care, including but  
12 not limited to the patient's medical condition or  
13 treatment options; or

14 (B) discussing with or communicating  
15 in good faith to a current, prospective, or former  
16 patient, or a party designated by a patient,  
17 information or opinions regarding the provisions,  
18 terms, requirements, or services of the health care  
19 plan as they relate to the medical needs of the  
20 patient.

21 (2) An insurer shall not in any way  
22 penalize, terminate, or refuse to compensate for  
23 covered services a physician or provider for  
24 discussing or communicating with a current,  
25 prospective, or former patient, or a party designated  
26 by a patient, pursuant to this section.

27 Revisor's Note

28 (1) Section 7(c)(1)(A), V.T.I.C. Article  
29 3.70-3C, as added by Chapter 1024, Acts of the 75th  
30 Legislature, Regular Session, 1997, refers to  
31 "including but not limited to." Throughout this  
32 chapter, the revised law omits "but not limited to" as  
33 unnecessary because Section 311.005(13), Government  
34 Code (Code Construction Act), applicable to the  
35 revised law, provides that "includes" and "including"  
36 are terms of enlargement and not of limitation and do  
37 not create a presumption that components not expressed  
38 are excluded.

39 (2) Section 7(c)(1)(B), V.T.I.C. Article  
40 3.70-3C, as added by Chapter 1024, Acts of the 75th  
41 Legislature, Regular Session, 1997, refers to a  
42 "health care plan." For consistency throughout this  
43 chapter, the revised law substitutes the defined term  
44 "health insurance policy" for "health care plan."

Revised Law

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) An insurer may not use any financial incentive or make payment to a physician or health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment. (V.T.I.C. Art. 3.70-3C, Sec. 7(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(d) An insurer shall not use any financial incentive or make payment to a physician or health care provider which acts directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the use of capitation as a method of payment.

[Sections 1301.069-1301.100 reserved for expansion]

## SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

Revised Law

Sec. 1301.101. DEFINITION. In this subchapter, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(a), as added Acts 75th Leg., R.S., Ch. 1024.)

## Source Law

Sec. 3A. (a) In this section, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy.

## Revised Law

Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A preferred provider may obtain acknowledgment of receipt of a claim for medical care or health care services under a health insurance policy by submitting the claim by United States mail, return receipt requested.

(b) An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge receipt of

1 the claim by an electronic transmission to the preferred provider  
2 and is not required to acknowledge receipt of the claim in writing.  
3 (V.T.I.C. Art. 3.70-3C, Sec. 3A(b), as added Acts 75th Leg., R.S.,  
4 Ch. 1024.)

5 Source Law

6 (b) A preferred provider for medical care or  
7 health care services under a health insurance policy  
8 may obtain acknowledgment of receipt of a claim for  
9 medical care or health care services under a health  
10 care plan by submitting the claim by United States  
11 mail, return receipt requested. An insurer or the  
12 contracted clearinghouse of an insurer that receives a  
13 claim electronically shall acknowledge receipt of the  
14 claim by an electronic transmission to the preferred  
15 provider and is not required to acknowledge receipt of  
16 the claim by the insurer in writing.

17 Revisor's Note

18 (1) Section 3A(b), V.T.I.C. Article 3.70-3C, as  
19 added by Chapter 1024, Acts of the 75th Legislature,  
20 Regular Session, 1997, refers to a "preferred provider  
21 for medical care or health care services under a health  
22 insurance policy." The revised law omits "for medical  
23 care or health care services under a health insurance  
24 policy" as unnecessary because those concepts are  
25 included in the definition of "preferred provider"  
26 under Section 1(10), V.T.I.C. Article 3.70-3C, as  
27 added by Chapter 1024, Acts of the 75th Legislature,  
28 Regular Session, 1997, revised as Section 1301.001(8).

29 (2) Section 3A(b), V.T.I.C. Article 3.70-3C, as  
30 added by Chapter 1024, Acts of the 75th Legislature,  
31 Regular Session, 1997, refers to a "health care plan."  
32 The revised law substitutes "health insurance policy"  
33 for "health care plan" for the reason stated in  
34 Revisor's Note (2) to Section 1301.067.

35 Revised Law

36 Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not  
37 later than the 45th day after the date on which an insurer receives  
38 a clean claim from a preferred provider, the insurer shall:

39 (1) pay the total amount of the claim in accordance



1 with the contract between the preferred provider and the insurer;

2 (2) pay the portion of the claim that is not in dispute  
3 and notify the preferred provider in writing why the remaining  
4 portion of the claim will not be paid; or

5 (3) notify the preferred provider in writing why the  
6 claim will not be paid. (V.T.I.C. Art. 3.70-3C, Sec. 3A(c), as  
7 added Acts 75th Leg., R.S., Ch. 1024.)

8 Source Law

9 (c) Not later than the 45th day after the date  
10 that the insurer receives a clean claim from a  
11 preferred provider, the insurer shall:

12 (1) pay the total amount of the claim in  
13 accordance with the contract between the preferred  
14 provider and the insurer;

15 (2) pay the portion of the claim that is  
16 not in dispute and notify the preferred provider in  
17 writing why the remaining portion of the claim will not  
18 be paid; or

19 (3) notify the preferred provider in  
20 writing why the claim will not be paid.

21 Revised Law

22 Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION  
23 BENEFIT CLAIMS. If a preferred provider or its designated agent  
24 authorizes treatment, a prescription benefit claim that is  
25 electronically adjudicated and electronically paid shall be paid  
26 not later than the 21st day after the date on which the treatment is  
27 authorized. (V.T.I.C. Art. 3.70-3C, Sec. 3A(d), as added Acts 75th  
28 Leg., R.S., Ch. 1024.)

29 Source Law

30 (d) If a prescription benefit claim is  
31 electronically adjudicated and electronically paid,  
32 and the preferred provider or its designated agent  
33 authorizes treatment, the claim must be paid not later  
34 than the 21st day after the treatment is authorized.

35 Revised Law

36 Sec. 1301.105. AUDITED CLAIMS. An insurer that  
37 acknowledges coverage of an insured under a health insurance policy  
38 but intends to audit a claim submitted by a preferred provider shall  
39 pay the charges submitted at 85 percent of the contracted rate on  
40 the claim not later than the 45th day after the date on which the  
41 insurer receives the claim from the preferred provider. Following

1 completion of the audit, any additional payment due a preferred  
2 provider or any refund due the insurer shall be made not later than  
3 the 30th day after the later of the date that:

4 (1) the preferred provider receives notice of the  
5 audit results; or

6 (2) any appeal rights of the insured are exhausted.  
7 (V.T.I.C. Art. 3.70-3C, Sec. 3A(e), as added Acts 75th Leg., R.S.,  
8 Ch. 1024.)

9 Source Law

10 (e) If the insurer acknowledges coverage of an  
11 insured under the health insurance policy but intends  
12 to audit the preferred provider claim, the insurer  
13 shall pay the charges submitted at 85 percent of the  
14 contracted rate on the claim not later than the 45th  
15 day after the date that the insurer receives the claim  
16 from the preferred provider. Following completion of  
17 the audit, any additional payment due a preferred  
18 provider or any refund due the insurer shall be made  
19 not later than the 30th day after the later of the date  
20 that:

21 (1) the preferred provider receives notice  
22 of the audit results; or

23 (2) any appeal rights of the insured are  
24 exhausted.

25 Revised Law

26 Sec. 1301.106. CLAIMS PROCESSING PROCEDURES. (a) An  
27 insurer shall provide a preferred provider with copies of all  
28 applicable utilization review policies and claim processing  
29 policies or procedures, including required data elements and claim  
30 formats.

31 (b) An insurer may, by contract with a preferred provider,  
32 add or change the data elements that must be submitted with a claim.

33 (c) Not later than the 60th day before the date of an  
34 addition or change in the data elements that must be submitted with  
35 a claim or any other change in an insurer's claim processing and  
36 payment procedures, the insurer shall provide written notice of the  
37 addition or change to each preferred provider. (V.T.I.C.  
38 Art. 3.70-3C, Secs. 3A(i), (j), (k), as added Acts 75th Leg., R.S.,  
39 Ch. 1024.)

40 Source Law

41 (i) The insurer shall provide a preferred

1 provider with copies of all applicable utilization  
2 review policies and claim processing policies or  
3 procedures, including required data elements and claim  
4 formats.

5 (j) An insurer may, by contract with a preferred  
6 provider, add or change the data elements that must be  
7 submitted with the preferred provider claim.

8 (k) Not later than the 60th day before the date  
9 of an addition or change in the data elements that must  
10 be submitted with a claim or any other change in an  
11 insurer's claim processing and payment procedures, the  
12 insurer shall provide written notice of the addition  
13 or change to each preferred provider.

14 Revised Law

15 Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS;  
16 ADMINISTRATIVE PENALTY. (a) An insurer that violates Section  
17 1301.103 or 1301.105 is liable to a preferred provider for the full  
18 amount of billed charges submitted on the claim or the amount  
19 payable under the contracted penalty rate, less any amount  
20 previously paid or any charge for a service that is not covered by  
21 the health insurance policy.

22 (b) In addition to any other penalty or remedy authorized by  
23 this code or another insurance law of this state, an insurer that  
24 violates Section 1301.103 or 1301.105 is subject to an  
25 administrative penalty under Chapter 84. The administrative  
26 penalty imposed under that chapter may not exceed \$1,000 for each  
27 day the claim remains unpaid in violation of Section 1301.103 or  
28 1301.105. (V.T.I.C. Art. 3.70-3C, Secs. 3A(f), (h), as added Acts  
29 75th Leg., R.S., Ch. 1024.)

30 Source Law

31 (f) An insurer that violates Subsection (c) or  
32 (e) of this section is liable to a preferred provider  
33 for the full amount of billed charges submitted on the  
34 claim or the amount payable under the contracted  
35 penalty rate, less any amount previously paid or any  
36 charge for a service that is not covered by the health  
37 insurance policy.

38 (h) In addition to any other penalty or remedy  
39 authorized by this code or another insurance law of  
40 this state, an insurer that violates Subsection (c) or  
41 (e) of this section is subject to an administrative  
42 penalty under Article 1.10E of this code. The  
43 administrative penalty imposed under that article may  
44 not exceed \$1,000 for each day the claim remains unpaid  
45 in violation of Subsection (c) or (e) of this section.

46 Revised Law

47 Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may

1 recover reasonable attorney's fees in an action to recover payment  
2 under this subchapter. (V.T.I.C. Art. 3.70-3C, Sec. 3A(g), as  
3 added Acts 75th Leg., R.S., Ch. 1024.)

4 Source Law

5 (g) A preferred provider may recover reasonable  
6 attorney's fees in an action to recover payment under  
7 this section.

8 Revised Law

9 Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH  
10 INSURER. This subchapter applies to a person with whom an insurer  
11 contracts to:

12 (1) process claims; or

13 (2) obtain the services of a preferred provider to  
14 provide medical care or health care to an insured under a health  
15 insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(m), as added  
16 Acts 75th Leg., R.S., Ch. 1024.)

17 Source Law

18 (m) This section applies to a person with whom  
19 an insurer contracts to process claims or to obtain the  
20 services of preferred providers to provide medical  
21 care or health care to insureds under a health  
22 insurance policy.

23 Revised Law

24 Sec. 1301.110. EXCEPTION. This subchapter does not apply  
25 to a claim submitted by a preferred provider who is a member of the  
26 legislature. (V.T.I.C. Art. 3.70-3C, Sec. 3A(l), as added Acts  
27 75th Leg., R.S., Ch. 1024.)

28 Source Law

29 (l) This section does not apply to a claim made  
30 by a preferred provider who is a member of the  
31 legislature.

32 Revisor's Note  
33 (End of Subchapter)

34 Section 3A(n), V.T.I.C. Article 3.70-3C, as added  
35 by Chapter 1024, Acts of the 75th Legislature, Regular  
36 Session, 1997, authorizes the commissioner of  
37 insurance to adopt rules as necessary to implement  
38 Section 3A, Article 3.70-3C, revised as this

1 subchapter. The revised law omits this provision as  
2 unnecessary because Section 9, Article 3.70-3C, as  
3 added by Chapter 1024, Acts of the 75th Legislature,  
4 Regular Session, 1997, revised as Section 1301.007,  
5 requires the commissioner of insurance to adopt rules  
6 to implement Article 3.70-3C, including Section 3A.  
7 The omitted law reads:

8 (n) The commissioner of insurance may  
9 adopt rules as necessary to implement this  
10 section.

11 [Sections 1301.111-1301.150 reserved for expansion]

12 SUBCHAPTER D. RELATIONS BETWEEN INSUREDS AND  
13 PREFERRED PROVIDERS

14 Revised Law

15 Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured  
16 is entitled to treatment and diagnostic techniques that are  
17 prescribed by the physician or health care provider included in the  
18 preferred provider benefit plan. (V.T.I.C. Art. 3.70-3C, Sec.  
19 3(e), as added Acts 75th Leg., R.S., Ch. 1024.)

20 Source Law

21 (e) Each insured patient shall have the right to  
22 treatment and diagnostic techniques as prescribed by  
23 the physician or other health care provider included  
24 in the preferred provider benefit plan.

25 Revisor's Note

26 Section 3(e), V.T.I.C. Article 3.70-3C, as added  
27 by Chapter 1024, Acts of the 75th Legislature, Regular  
28 Session, 1997, refers to an "insured patient." The  
29 revised law substitutes "insured" for "insured  
30 patient" for consistency throughout this chapter.

31 Revised Law

32 Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An  
33 insurer shall establish reasonable procedures for ensuring a  
34 transition of insureds to physicians or health care providers and  
35 for continuity of treatment.

36 (b) An insurer shall:

1 (1) provide, subject to Section 1301.160, reasonable  
2 advance notice to an insured of the impending termination of the  
3 participation in the plan of a physician or health care provider who  
4 is currently treating the insured; and

5 (2) in the event of termination of a preferred  
6 provider's participation in the plan, make available to the insured  
7 a current listing of preferred providers.

8 (c) A contract between an insurer and a physician or health  
9 care provider must include a procedure for resolving disputes  
10 regarding the necessity for continued treatment by the physician or  
11 provider. (V.T.I.C. Art. 3.70-3C, Secs. 4(a), (d), as added Acts  
12 75th Leg., R.S., Ch. 1024.)

#### 13 Source Law

14 Sec. 4. (a) The insurer shall establish  
15 reasonable procedures for assuring a transition of  
16 insureds to physicians or health care providers and  
17 for continuity of treatment. Insurers shall provide,  
18 subject to Section 6(e) of this article, reasonable  
19 advance notice to the insured of the impending  
20 termination from the plan of a physician or health care  
21 provider who is currently treating the insured and in  
22 the event of termination of a preferred provider's  
23 participation in the plan shall make available to the  
24 insured a current listing of preferred providers.

25 (d) Contracts between an insurer, physicians,  
26 and health care providers shall include procedures for  
27 resolving disputes regarding the necessity for  
28 continued treatment by a physician or provider.

#### 29 Revised Law

30 Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

31 (1) "Life-threatening" means a disease or condition  
32 for which the likelihood of death is probable unless the course of  
33 the disease or condition is interrupted.

34 (2) "Special circumstances" means a condition  
35 regarding which the treating physician or health care provider  
36 reasonably believes that discontinuing care by the treating  
37 physician or provider could cause harm to the insured. Examples of  
38 an insured who has a special circumstance include an insured with a  
39 disability, acute condition, or life-threatening illness or an  
40 insured who is past the 24th week of pregnancy.

1 (b) Each contract between an insurer and a physician or  
2 health care provider must provide that the termination of the  
3 physician's or provider's participation in a preferred provider  
4 benefit plan, except for reason of medical competence or  
5 professional behavior, does not:

6 (1) release the physician or health care provider from  
7 the generally recognized obligation to:

8 (A) treat an insured whom the physician or  
9 provider is currently treating; and

10 (B) cooperate in arranging for appropriate  
11 referrals; or

12 (2) release the insurer from the obligation to  
13 reimburse the physician or health care provider or, if applicable,  
14 the insured, at the same preferred provider rate if, at the time a  
15 physician's or provider's participation is terminated, an insured  
16 whom the physician or provider is currently treating has special  
17 circumstances in accordance with the dictates of medical prudence.

18 (c) The treating physician or health care provider shall  
19 identify a special circumstance. The treating physician or health  
20 care provider shall:

21 (1) request that the insured be permitted to continue  
22 treatment under the physician's or provider's care; and

23 (2) agree not to seek payment from the insured of any  
24 amount for which the insured would not be responsible if the  
25 physician or provider were still a preferred provider. (V.T.I.C.  
26 Art. 3.70-3C, Secs. 1(7), 4(b), (c), as added Acts 75th Leg., R.S.,  
27 Ch. 1024.)

28 Source Law

29 [Sec. 1]

30 (7) "Life threatening" means a disease or  
31 condition for which the likelihood of death is  
32 probable unless the course of the disease or condition  
33 is interrupted.

34 [Sec. 4]

35 (b) Each contract between an insurer and a  
36 physician or health care provider must provide that  
37 the termination of a preferred provider's  
38 participation in the plan, except for reason of

1 medical competence or professional behavior, shall not  
2 release the physician or health care provider from the  
3 generally recognized obligation to treat the insured  
4 and to cooperate in arranging for appropriate  
5 referrals; nor does it release the insurer from the  
6 obligation to reimburse the physician or health care  
7 provider or, if applicable, the insured at the same  
8 preferred provider rate if, at the time of the  
9 preferred provider's termination, the insured has  
10 special circumstances such as a disability, acute  
11 condition, or life-threatening illness or is past the  
12 24th week of pregnancy and is receiving treatment in  
13 accordance with the dictates of medical prudence.

14 (c) For purposes of Subsection (b) of this  
15 section, "special circumstances" means a condition  
16 such that the treating physician or health care  
17 provider reasonably believes that discontinuing care  
18 by the treating physician or provider could cause harm  
19 to the patient. Special circumstances shall be  
20 identified by the treating physician or health care  
21 provider, who must request that the insured be  
22 permitted to continue treatment under the physician's  
23 or provider's care and agree not to seek payment from  
24 the patient of any amounts for which the insured would  
25 not be responsible if the physician or provider were  
26 still a preferred provider.

#### 27 Revised Law

28 Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF  
29 INSURER. (a) Except as provided by Subsection (b), Sections  
30 1301.152 and 1301.153 do not extend an insurer's obligation to  
31 reimburse the terminated physician or provider or, if applicable,  
32 the insured at the preferred provider level of coverage for ongoing  
33 treatment of an insured after:

34 (1) the 90th day after the effective date of the  
35 termination; or

36 (2) if the insured has been diagnosed as having a  
37 terminal illness at the time of the termination, the expiration of  
38 the nine-month period after the effective date of the termination.

39 (b) If an insured is past the 24th week of pregnancy at the  
40 time of termination, an insurer's obligation to reimburse, at the  
41 preferred provider level of coverage, the physician or provider or,  
42 if applicable, the insured, extends through delivery of the child,  
43 immediate postpartum care, and the follow-up checkup within the  
44 six-week period after delivery. (V.T.I.C. Art. 3.70-3C, Sec. 4(e),  
45 as added Acts 75th Leg., R.S., Ch. 1024.)

#### 46 Source Law

47 (e) This section does not extend the obligation



1 of the insurer to reimburse, at the preferred provider  
2 level of coverage, the terminated physician or health  
3 care provider or, if applicable, the insured for  
4 ongoing treatment of an insured after the 90th day from  
5 the effective date of the termination, or beyond nine  
6 months in the case of an enrollee who at the time of the  
7 termination has been diagnosed with a terminal  
8 illness. However, the obligation of the insurer to  
9 reimburse, at the preferred provider level of  
10 coverage, the terminated physician or health care  
11 provider or, if applicable, the insured who at the time  
12 of the termination is past the 24th week of pregnancy,  
13 extends through delivery of the child, immediate  
14 post-partum care, and the follow-up checkup within the  
15 first six weeks of delivery.

16 Revised Law

17 Sec. 1301.155. EMERGENCY CARE. (a) In this section,  
18 "emergency care" means health care services provided in a hospital  
19 emergency facility or comparable facility to evaluate and stabilize  
20 a medical condition of a recent onset and severity, including  
21 severe pain, that would lead a prudent layperson possessing an  
22 average knowledge of medicine and health to believe that the  
23 person's condition, sickness, or injury is of such a nature that  
24 failure to get immediate medical care could result in:

- 25 (1) placing the person's health in serious jeopardy;  
26 (2) serious impairment to bodily functions;  
27 (3) serious dysfunction of a bodily organ or part;  
28 (4) serious disfigurement; or  
29 (5) in the case of a pregnant woman, serious jeopardy  
30 to the health of the fetus.

31 (b) If an insured cannot reasonably reach a preferred  
32 provider, an insurer shall provide reimbursement for the following  
33 emergency care services at the preferred level of benefits until  
34 the insured can reasonably be expected to transfer to a preferred  
35 provider:

36 (1) a medical screening examination or other  
37 evaluation required by state or federal law to be provided in the  
38 emergency facility of a hospital that is necessary to determine  
39 whether a medical emergency condition exists;

40 (2) necessary emergency care services, including the  
41 treatment and stabilization of an emergency medical condition; and

1 (3) services originating in a hospital emergency  
2 facility following treatment or stabilization of an emergency  
3 medical condition. (V.T.I.C. Art. 3.70-3C, Secs. 1(1), 5, as added  
4 Acts 75th Leg., R.S., Ch. 1024.)

5 Source Law

6 Sec. 1. In this article:

7 (1) "Emergency care" means health care  
8 services provided in a hospital emergency facility or  
9 comparable facility to evaluate and stabilize medical  
10 conditions of a recent onset and severity, including  
11 but not limited to severe pain, that would lead a  
12 prudent layperson possessing an average knowledge of  
13 medicine and health to believe that the person's  
14 condition, sickness, or injury is of such a nature that  
15 failure to get immediate medical care could result in:

16 (A) placing the patient's health in  
17 serious jeopardy;

18 (B) serious impairment to bodily  
19 functions;

20 (C) serious dysfunction of any bodily  
21 organ or part;

22 (D) serious disfigurement; or

23 (E) in the case of a pregnant woman,  
24 serious jeopardy to the health of the fetus.

25 Sec. 5. If the insured cannot reasonably reach a  
26 preferred provider, an insurer shall provide  
27 reimbursement for the following emergency care  
28 services at the preferred level of benefits until the  
29 insured can reasonably be expected to transfer to a  
30 preferred provider:

31 (1) any medical screening examination or  
32 other evaluation required by state or federal law to be  
33 provided in the emergency facility of a hospital which  
34 is necessary to determine whether a medical emergency  
35 condition exists;

36 (2) necessary emergency care services  
37 including the treatment and stabilization of an  
38 emergency medical condition; and

39 (3) services originating in a hospital  
40 emergency facility following treatment or  
41 stabilization of an emergency medical condition.

42 Revised Law

43 Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer  
44 shall comply with Subchapter B, Chapter 542, with respect to prompt  
45 payment to insureds. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as  
46 added Acts 75th Leg., R.S., Ch. 1024.)

47 Source Law

48 (m) An insurer shall comply with Article 21.55  
49 of this code with respect to prompt payment of  
50 insureds. . . .

51 Revised Law

52 Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health

1 insurance policy, health benefit plan certificate, endorsement,  
2 amendment, application, or rider must:

- 3 (1) be written in plain language;
- 4 (2) be in a readable and understandable format; and
- 5 (3) comply with all applicable requirements relating  
6 to minimum readability requirements. (V.T.I.C. Art. 3.70-3C, Sec.  
7 6(a), as added Acts 75th Leg., R.S., Ch. 1024.)

8 Source Law

9 Sec. 6. (a) All health insurance policies,  
10 health benefit plan certificates, endorsements,  
11 amendments, applications, or riders shall be written  
12 in plain language, must be in a readable and  
13 understandable format, and must comply with all  
14 applicable requirements relating to minimum  
15 readability requirements.

16 Revised Law

17 Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER  
18 BENEFIT PLANS. (a) In this section, "prospective insured" means:

19 (1) for group coverage, an individual or an  
20 individual's dependent who is eligible for coverage under a health  
21 insurance policy issued to the group; or

22 (2) for individual coverage, an individual or an  
23 individual's dependent who is eligible for coverage and who has  
24 expressed an interest in purchasing an individual health insurance  
25 policy.

26 (b) An insurer shall provide to a current or prospective  
27 group contract holder or current or prospective insured on request  
28 an accurate written description of the terms of the health  
29 insurance policy to allow the current or prospective group contract  
30 holder or current or prospective insured to make comparisons and an  
31 informed decision before selecting among health care plans. The  
32 description must be in a readable and understandable format as  
33 prescribed by the commissioner and must include a current list of  
34 preferred providers. The insurer may satisfy this requirement by  
35 providing its handbook if:

36 (1) the handbook's content is substantively similar to  
37 and achieves the same level of disclosure as the written

1 description prescribed by the commissioner; and

2 (2) the current list of preferred providers is  
3 provided.

4 (c) An insurer or an agent or representative of an insurer  
5 may not use or distribute, or permit the use or distribution of,  
6 information for prospective insureds that is untrue or misleading.

7 (V.T.I.C. Art. 3.70-3C, Secs. 1(11), 6(b), (d), as added Acts 75th  
8 Leg., R.S., Ch. 1024.)

9 Source Law

10 [Sec. 1]

11 (11) "Prospective insured" means:

12 (A) for group coverage, an  
13 individual, including dependents, eligible for  
14 coverage under a health insurance policy issued to the  
15 group; or

16 (B) for individual coverage, an  
17 individual, including dependents, eligible for  
18 coverage who has expressed an interest in purchasing  
19 an individual health insurance policy.

20 [Sec. 6]

21 (b) The insurer shall provide to a current or  
22 prospective group contract holder or current or  
23 prospective insured on request an accurate written  
24 description of the terms and conditions of the policy  
25 to allow the current or prospective group contract  
26 holder or current or prospective insured to make  
27 comparisons and informed decisions before selecting  
28 among health care plans. The written description must  
29 be in a readable and understandable format as  
30 prescribed by the commissioner and must include a  
31 current list of preferred providers. The insurer may  
32 provide its handbook to satisfy this requirement  
33 provided the handbook's content is substantively  
34 similar to and achieves the same level of disclosure as  
35 the written description prescribed by the commissioner  
36 and the current list of physicians and health care  
37 providers is provided.

38 (d) No insurer, or agent or representative of an  
39 insurer, may cause or permit the use or distribution of  
40 prospective insured information which is untrue or  
41 misleading.

42 Revised Law

43 Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A  
44 current list of preferred providers shall be provided to each  
45 insured at least annually. (V.T.I.C. Art. 3.70-3C, Sec. 6(c), as  
46 added Acts 75th Leg., R.S., Ch. 1024.)

47 Source Law

48 (c) A current list of preferred providers shall  
49 be provided to all insureds no less than annually.



1 preferred provider benefit plan. For consistency  
2 throughout this chapter, the revised law substitutes  
3 "insured" for "enrollee."

4 Revised Law

5 Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An  
6 insurer may not engage in any retaliatory action against an  
7 insured, including canceling or refusing to renew a health  
8 insurance policy, because the insured or a person acting on the  
9 insured's behalf has:

10 (1) filed a complaint against the insurer or against a  
11 preferred provider; or

12 (2) appealed a decision of the insurer. (V.T.I.C.  
13 Art. 3.70-3C, Sec. 7(a), as added Acts 75th Leg., R.S., Ch. 1024.)

14 Source Law

15 Sec. 7. (a) No insurer shall engage in any  
16 retaliatory action against an insured, including  
17 cancellation of or refusal to renew a policy, because  
18 the insured, or a person acting on behalf of the  
19 insured, has filed a complaint against the insurer or  
20 against a preferred provider or has appealed a  
21 decision of the insurer.

22 [Sections 1301.162-1301.200 reserved for expansion]

23 SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

24 Revised Law

25 Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE  
26 FIRST ASSISTANTS. A preferred provider may not refuse to:

27 (1) contract with a nurse first assistant, as defined  
28 by Section 301.1525, Occupations Code, to be included in the  
29 provider's network; or

30 (2) reimburse the nurse first assistant for a covered  
31 service that a physician has requested the nurse first assistant to  
32 perform. (V.T.I.C. Art. 3.70-3C, Sec. 3(o), as added Acts 75th  
33 Leg., R.S., Ch. 1024.)

34 Source Law

35 (o) A preferred provider may not refuse to  
36 contract with a nurse first assistant, as defined by  
37 Section 301.1525, Occupations Code, to be included in  
38 the provider's network or refuse to reimburse the nurse  
39 first assistant for a covered service that a physician

has requested the nurse first assistant to perform.

[Chapters 1302-1350 reserved for expansion]

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

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CHAPTER 1351. HOME HEALTH SERVICES

Revised Law

Sec. 1351.001. DEFINITIONS. In this chapter:

(1) "Health services" includes:

- (A) skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;
- (B) physical, occupational, speech, or respiratory therapy;
- (C) the services of a home health aide under the supervision of a registered nurse; and
- (D) the furnishing of medical equipment and supplies other than drugs or medicines.

(2) "Home health agency" means a business that:

- (A) provides home health services; and
- (B) is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

1           (3) "Home health services" means the provision of  
2 health services for payment or other consideration in a patient's  
3 residence under a plan of care that is:

4           (A) established, approved in writing, and  
5 reviewed at least every two months by the attending physician; and

6           (B) certified by the attending physician as  
7 necessary for medical purposes. (V.T.I.C. Art. 3.70-3B, Sec. 1.)

8                           Source Law

9           Art. 3.70-3B

10          Sec. 1. As used in this article:

11           (1) "Health services" includes:

12               (A) skilled nursing by a registered  
13 nurse or licensed vocational nurse under the  
14 supervision of at least one registered nurse and at  
15 least one physician;

16               (B) physical, occupational, speech,  
17 or respiratory therapy;

18               (C) the service of a home health aide  
19 under the supervision of a registered nurse; and

20               (D) the furnishing of medical  
21 equipment and medical supplies other than drugs and  
22 medicines.

23           (2) "Home health agency" means a business  
24 that provides home health service and is licensed by  
25 the Texas Department of Health under Chapter 142,  
26 Health and Safety Code.

27           (3) "Home health service" means the  
28 provision of a health service for payment or other  
29 consideration in a patient's residence under a plan of  
30 care established, approved in writing, and reviewed at  
31 least every two months by the attending physician and  
32 certified by the attending physician as necessary for  
33 medical purposes.

34                           Revisor's Note

35          Section 1, V.T.I.C. Article 3.70-3B, refers to a  
36 home health agency that is "licensed by the Texas  
37 Department of Health under Chapter 142, Health and  
38 Safety Code." Under Section 1.24, Chapter 1505, Acts  
39 of the 76th Legislature, Regular Session, 1999,  
40 responsibility for licensing agencies under Chapter  
41 142 was transferred from the Texas Department of  
42 Health to the Texas Department of Human Services. The  
43 revised law is drafted accordingly.

44                           Revised Law

45          Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This  
46 chapter applies to a group health benefit plan that is delivered or



1 issued for delivery in this state and that is a group policy of  
2 accident and health insurance, including a policy issued by a group  
3 hospital service corporation operating under Chapter 842.

4 (b) This chapter applies to an accident and health insurance  
5 policy issued by a stipulated premium company subject to Chapter  
6 884. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part); Art. 3.70-8, Secs.  
7 (a) (part), (b).)

#### 8 Source Law

9 [Art. 3.70-3B]

10 Sec. 2. (a) . . . a group policy of accident  
11 and sickness insurance, including policies issued by  
12 companies subject to Chapter 20 of this code, may not  
13 be delivered or issued for delivery to any person in  
14 this state [unless benefits for home health service  
15 provided by a licensed home health agency are included  
16 in that group policy.] . . .

17 Art. 3.70-8. [(a) Nothing in this Act shall  
18 apply to . . . any blanket or group policy of insurance  
19 except as provided] . . . in article 3.70-3B . . . .

20 (b) This Act applies to a health, accident,  
21 sickness, and hospitalization policy issued by a  
22 stipulated premium insurer subject to Chapter 884 of  
23 this code.

#### 24 Revisor's Note

25 (1) Section 2(a), V.T.I.C. Article 3.70-3B,  
26 refers to a group policy of "accident and sickness  
27 insurance." Similarly, Sections (a) and (b), V.T.I.C.  
28 Article 3.70-8, refer to a "blanket or group policy of  
29 insurance," meaning a policy of accident and sickness  
30 insurance described by Section (B), V.T.I.C. Article  
31 3.70-2, and to a "health, accident, sickness, and  
32 hospitalization policy," respectively. For  
33 consistency with modern usage, the revised law  
34 substitutes "accident and health" for "accident and  
35 sickness" and for "health, accident, sickness, and  
36 hospitalization." Comparable changes necessary to  
37 ensure consistent use of terminology have been made  
38 throughout this chapter.

39 (2) Section 2(a), V.T.I.C. Article 3.70-3B,  
40 refers to "policies issued by companies" subject to

1 V.T.I.C. Chapter 20, revised as Chapter 842 of this  
2 code. The term most frequently used to refer to such a  
3 company is "group hospital service corporation."  
4 Consequently, the revised law substitutes "group  
5 hospital service corporation" for "companies" to  
6 provide for consistent use of terminology throughout  
7 this code.

#### 8 Revised Law

9 Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER  
10 LAW. The provisions of Chapter 1201, including provisions  
11 relating to the applicability, purpose, and enforcement of that  
12 chapter, the construction of policies under that chapter,  
13 rulemaking under that chapter, and definitions of terms applicable  
14 in that chapter, apply to this chapter. (New.)

#### 15 Revisor's Note

16 Chapter 397, Acts of the 54th Legislature,  
17 Regular Session, 1955, published as V.T.I.C. Articles  
18 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,  
19 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and  
20 3.70-11, contains general provisions applicable to  
21 V.T.I.C. Article 3.70-3B, revised as this chapter. It  
22 is clear that the legislature intended the general  
23 provisions of Chapter 397 to apply to Article 3.70-3B  
24 because when the legislature enacted Article 3.70-3B,  
25 it also amended V.T.I.C. Article 3.70-8, a  
26 nonapplicability provision derived from Chapter 397,  
27 to provide an exception for Article 3.70-3B. The  
28 majority of the articles derived from Chapter 397 are  
29 revised in this code as Chapter 1201. Section 1351.003  
30 is added to indicate the applicability of the general  
31 provisions of those articles to this chapter. For the  
32 convenience of the reader, the revised law includes  
33 general descriptions of some of the applicable  
34 provisions of Chapter 1201.

Revised Law

Sec. 1351.004. EXCEPTION. This chapter does not apply to:

(1) a group policy of accident and health insurance that provides coverage only for:

(A) a specified disease or diseases;

(B) vision care;

(C) dental care;

(D) hospital indemnity;

(E) prescription drugs; or

(F) other limited benefits;

(2) a blanket insurance policy, as described by Chapter 1251;

(3) a short-term travel insurance policy;

(4) an accident-only insurance policy;

(5) a hospital indemnity insurance policy;

(6) a limited or specified disease insurance policy;

(7) an insurance policy or contract issued under a right of conversion; or

(8) an insurance policy or contract designed for issuance to a person eligible for Medicare coverage. (V.T.I.C. Art. 3.70-3B, Sec. 2(c).)

## Source Law

(c) This article does not apply to:

(1) group accident and sickness policies that provide only coverage for a specified disease or diseases, vision care, dental care, hospital indemnity, prescription drugs, or other limited benefits;

(2) blanket insurance policies, as defined in Article 3.51-6, Insurance Code;

(3) short-term travel insurance;

(4) accident-only insurance;

(5) hospital indemnity policies;

(6) limited or specified disease policies;

(7) insurance policies or contracts issued pursuant to a right of conversion; or

(8) insurance policies or contracts designed for issuance to persons eligible for Medicare.

## Revised Law

Sec. 1351.005. COVERAGE REQUIRED. Except as provided by Section 1351.008, a group health benefit plan must provide coverage

1 for home health services provided by a home health agency.  
2 (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

3 Source Law

4 Sec. 2. (a) Except as provided by Subsections  
5 (b) and (c) of this section, [a group policy of  
6 accident and sickness insurance, including policies  
7 issued by companies subject to Chapter 20 of this code,  
8 may not be delivered or issued for delivery to any  
9 person in this state] unless benefits for home health  
10 service provided by a licensed home health agency are  
11 included in that group policy. . . .

12 Revisor's Note

13 (1) Section 2(a), V.T.I.C. Article 3.70-3B,  
14 prohibits the delivery or issuance of certain group  
15 policies "[e]xcept as provided by Subsections . . .  
16 (c) of this section." Section 2(c), V.T.I.C. Article  
17 3.70-3B, revised as Section 1351.004, specifies the  
18 types of coverage exempt from the application of  
19 V.T.I.C. Article 3.70-3B, revised as this chapter.  
20 The revised law omits "[e]xcept as provided by  
21 Subsections . . . (c) of this section" as unnecessary  
22 because if a policy is exempt under Section 2(c), then  
23 the policy is not subject to the prohibition stated in  
24 Section 2(a).

25 (2) Section 2(a), V.T.I.C. Article 3.70-3B,  
26 refers to a "licensed home health agency." The revised  
27 law omits "licensed" as unnecessary because "home  
28 health agency" is defined by Section 1(2) of that  
29 article, revised as Section 1351.001(2), to mean a  
30 business that is licensed by the Texas Department of  
31 Human Services.

32 Revised Law

33 Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES:  
34 PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan  
35 issuer may not provide reimbursement for home health services  
36 provided under the plan unless the attending physician certifies  
37 that hospitalization or confinement in a skilled facility would be

required if a treatment plan for home health care were not provided.  
(V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Source Law

(a) . . . Home health services provided under this section may not be reimbursed unless the attending physician certifies that hospitalization or confinement in a skilled facility would otherwise be required if a treatment plan for home health care was not provided.

Revised Law

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE PERMITTED. (a) A group health benefit plan may include:

(1) a limitation on the number of visits for home health services for which benefits are payable, subject to Subsection (b);

(2) an exclusion for home health services coverage for:

(A) custodial care;

(B) services provided by an individual who:

(i) resides in the covered individual's home; or

(ii) is a member of the covered individual's family; or

(C) services provided to a covered individual who is eligible for Medicare coverage;

(3) annual deductible and coinsurance provisions for home health services coverage that are not less favorable than the deductible or coinsurance provisions applicable to hospital services coverage under the plan; and

(4) other coverage limitations or exclusions consistent with the remaining provisions of the plan.

(b) A limitation under Subsection (a)(1) may not limit each individual covered under the plan to fewer than 60 visits in any calendar year or continuous 12-month period.

(c) For purposes of this section, each of the following is considered to be one visit for home health services:

1           (1) a visit by a representative of a home health  
2 agency;

3           (2) four hours of home health aide service; and

4           (3) if home health aide service extends beyond four  
5 hours, each additional four hours or portion of that four-hour  
6 period. (V.T.I.C. Art. 3.70-3B, Secs. 3(a), (b), (c).)

7                           Source Law

8           Sec. 3. (a) A policy of accident or sickness  
9 insurance issued under Subsection (a) of Section 2 of  
10 this article may include:

11                   (1) a limitation on the number of home  
12 health care visits for which benefits are payable,  
13 provided the number of visits for which benefits are  
14 payable may not be fewer than 60 visits in any calendar  
15 year or in any continuous period of 12 months for each  
16 person covered under the policy or contract;

17                   (2) annual deductible and coinsurance  
18 provisions provided that those provisions are not less  
19 favorable than the deductible or coinsurance  
20 provisions applicable to covered hospital services  
21 under the policy; and

22                   (3) an exclusion for home health benefits  
23 for custodial care, for services provided by a person  
24 who resides in the covered person's home or is a member  
25 of the covered person's family, or for services  
26 provided to a covered person who is eligible for  
27 Medicare.

28           (b) For the purposes of Subdivision (1) of  
29 Subsection (a) of this section, each visit by a  
30 representative of a home health agency is considered  
31 as one home health care visit, four hours of home  
32 health aide service is considered as one home health  
33 care visit, and if service extends beyond four hours,  
34 each four hours or portion of that period is considered  
35 as one home health care visit.

36           (c) Home health benefits may be subject to  
37 limitations and exclusions consistent with the balance  
38 of the policy or contract.

39                           Revised Law

40           Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER;  
41 NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group  
42 health benefit plan rejects in writing the coverage required under  
43 this chapter, the plan issuer:

44                   (1) may not include the coverage in the plan; and

45                   (2) is not required to:

46                           (A) offer the coverage to the plan holder; or

47                           (B) provide the coverage under the plan.

48           (b) If a plan holder rejects in writing the coverage  
49 required under this chapter, the plan holder and the plan issuer may

negotiate coverage for home health services other than the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 2(b).)

Source Law

(b) An insurer may not include the coverage required by Subsection (a) of this section if the policyholder rejects the coverage in writing. If a policyholder rejects the coverage in writing as provided by this subsection, the insurer has no further obligation to offer or to provide coverage for services under this article, provided that nothing contained herein shall prevent the policyholder and insurer from negotiating other benefits for home health services following policyholder rejection as provided above.

Revised Law

Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This chapter does not preclude a group health benefit plan issuer from providing coverage for home health services that exceeds the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 3(d).)

Source Law

(d) This article does not preclude a group policy of accident and sickness insurance, including policies issued by companies licensed pursuant to Chapter 20 of this code, from including home health services in excess of those provided in this article.

CHAPTER 1352. BRAIN INJURY

Sec. 1352.001. APPLICABILITY OF CHAPTER . . . . . 895

Sec. 1352.002. EXCEPTION. . . . . 897

Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED . . . . . 898

Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED . . . 899

CHAPTER 1352. BRAIN INJURY

Revised Law

Sec. 1352.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is

1 offered by:

- 2 (1) an insurance company;
- 3 (2) a group hospital service corporation operating  
4 under Chapter 842;
- 5 (3) a fraternal benefit society operating under  
6 Chapter 885;
- 7 (4) a stipulated premium company operating under  
8 Chapter 884;
- 9 (5) a reciprocal exchange operating under Chapter 942;
- 10 (6) a Lloyd's plan operating under Chapter 941;
- 11 (7) a health maintenance organization operating under  
12 Chapter 843;
- 13 (8) a multiple employer welfare arrangement that holds  
14 a certificate of authority under Chapter 846; or
- 15 (9) an approved nonprofit health corporation that  
16 holds a certificate of authority under Chapter 844. (V.T.I.C.  
17 Art. 21.53Q, Secs. 1(a), (b).)

18 Source Law

19 Art. 21.53Q

20 Sec. 1. (a) This article applies only to a  
21 health benefit plan that provides benefits for medical  
22 or surgical expenses incurred as a result of a health  
23 condition, accident, or sickness, including an  
24 individual, group, blanket, or franchise insurance  
25 policy or insurance agreement, a group hospital  
26 service contract, or an individual or group evidence  
27 of coverage or similar coverage document that is  
28 offered by:

- 29 (1) an insurance company;
- 30 (2) a group hospital service corporation  
31 operating under Chapter 20 of this code;
- 32 (3) a fraternal benefit society operating  
33 under Chapter 10 of this code;
- 34 (4) a stipulated premium insurance company  
35 operating under Chapter 22 of this code;
- 36 (5) a reciprocal exchange operating under  
37 Chapter 19 of this code;
- 38 (6) a Lloyd's plan operating under Chapter  
39 18 of this code;
- 40 (7) a health maintenance organization  
41 operating under the Texas Health Maintenance  
42 Organization Act (Chapter 20A, Vernon's Texas  
43 Insurance Code);
- 44 (8) a multiple employer welfare  
45 arrangement that holds a certificate of authority  
46 under Article 3.95-2 of this code; or
- 47 (9) an approved nonprofit health  
48 corporation that holds a certificate of authority  
49 under Article 21.52F of this code.



1 (b) This article applies to a small employer  
2 health benefit plan written under Chapter 26 of this  
3 code.

4 Revised Law

5 Sec. 1352.002. EXCEPTION. This chapter does not apply to:

6 (1) a plan that provides coverage:

7 (A) only for a specified disease or for another  
8 limited benefit other than an accident policy;

9 (B) only for accidental death or dismemberment;

10 (C) for wages or payments in lieu of wages for a  
11 period during which an employee is absent from work because of  
12 sickness or injury;

13 (D) as a supplement to a liability insurance  
14 policy;

15 (E) for credit insurance;

16 (F) only for dental or vision care;

17 (G) only for hospital expenses; or

18 (H) only for indemnity for hospital confinement;

19 (2) a Medicare supplemental policy as defined by  
20 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),  
21 as amended;

22 (3) a workers' compensation insurance policy;

23 (4) medical payment insurance coverage provided under  
24 a motor vehicle insurance policy; or

25 (5) a long-term care insurance policy, including a  
26 nursing home fixed indemnity policy, unless the commissioner  
27 determines that the policy provides benefit coverage so  
28 comprehensive that the policy is a health benefit plan as described  
29 by Section 1352.001. (V.T.I.C. Art. 21.53Q, Sec. 1(c).)

30 Source Law

31 (c) This article does not apply to:

32 (1) a plan that provides coverage:

33 (A) only for benefits for a specified  
34 disease or for another limited benefit other than an  
35 accident policy;

36 (B) only for accidental death or  
37 dismemberment;

38 (C) for wages or payments in lieu of  
39 wages for a period during which an employee is absent  
40 from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

#### Revised Law

Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this chapter may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits applicable to other similar coverage provided under the health benefit plan.

(c) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.53Q, Sec. 2.)

#### Source Law

Sec. 2. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this article may be

1 subject to deductibles, copayments, coinsurance, or  
2 annual or maximum payment limits that are consistent  
3 with deductibles, copayments, coinsurance, and annual  
4 or maximum payment limits applicable to other similar  
5 coverage under the plan.

6 (c) The commissioner shall adopt rules as  
7 necessary to implement this section.

8 Revised Law

9 Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL  
10 REQUIRED. (a) In this section, "preauthorization" means the  
11 provision of a reliable representation to a physician or health  
12 care provider of whether a health benefit plan issuer will pay the  
13 physician or provider for proposed medical or health care services  
14 if the physician or provider provides those services to the patient  
15 for whom the services are proposed. The term includes  
16 precertification, certification, recertification, or any other  
17 activity that involves providing a reliable representation by the  
18 issuer to a physician or health care provider.

19 (b) The commissioner by rule shall require a health benefit  
20 plan issuer to provide adequate training to personnel responsible  
21 for preauthorization of coverage or utilization review under the  
22 plan. The purpose of the training is to prevent denial of coverage  
23 in violation of Section 1352.003 and to avoid confusion of medical  
24 benefits with mental health benefits. (V.T.I.C. Art. 21.53Q, Sec.  
25 3.)

26 Source Law

27 Sec. 3. (a) In this section, "preauthorization"  
28 means the provision of a reliable representation to a  
29 physician or health care provider of whether the  
30 issuer of a health benefit plan will pay the physician  
31 or provider for proposed medical or health care  
32 services if the physician or provider renders those  
33 services to the patient for whom the services are  
34 proposed. The term includes precertification,  
35 certification, recertification, or any other activity  
36 that involves providing a reliable representation by  
37 the issuer of a health benefit plan to a physician or  
38 health care provider.

39 (b) The commissioner by rule shall require the  
40 issuer of a health benefit plan to provide adequate  
41 training to personnel responsible for  
42 preauthorization of coverage or utilization review  
43 under the plan to prevent wrongful denial of coverage  
44 required under this article and to avoid confusion of  
45 medical benefits with mental health benefits.

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5 CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS

6 UNDER MANAGED CARE PLANS

7 Revised Law

8 Sec. 1353.001. PROHIBITED CONDUCT. A managed care entity

9 may not:

10 (1) require a physician participating in a managed

11 care plan to issue an immunization or vaccination protocol for an

12 immunization or vaccination to be administered to an enrollee in

13 the plan;

14 (2) limit an enrollee's benefits for immunizations or

15 vaccinations to circumstances in which an immunization or

16 vaccination protocol is issued;

17 (3) provide a financial incentive to a physician to

18 issue an immunization or vaccination protocol; or

19 (4) impose a financial or other penalty on a physician

20 who refuses to issue an immunization or vaccination protocol.

21 (V.T.I.C. Art. 21.53K, Sec. 1.)

22 Source Law

23 Art. 21.53K

24 Sec. 1. (a) A managed care entity may not

25 require a physician participating in a managed care

26 plan to issue an immunization or vaccination protocol

27 for an immunization or vaccination to be administered

28 to an enrollee in the plan.

29 (b) This section prohibits a managed care entity

30 from:

31 (1) limiting benefits to enrollees for

32 immunizations or vaccinations to circumstances in

33 which an immunization or vaccination protocol is

34 issued;

35 (2) providing financial incentives to

36 physicians to issue an immunization or vaccination

37 protocol; or

38 (3) imposing a financial or other penalty

39 on a physician who refuses to issue an immunization or

40 vaccination protocol.

41 Revised Law

42 Sec. 1353.002. RULES. The commissioner may adopt rules to

1 implement this chapter. (V.T.I.C. Art. 21.53K, Sec. 2.)

2 Source Law

3 Sec. 2. The commissioner may adopt rules to  
4 implement this article.

5 CHAPTER 1354. ELIGIBILITY FOR BENEFITS  
6 FOR ALZHEIMER'S DISEASE

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9 CHAPTER 1354. ELIGIBILITY FOR BENEFITS  
10 FOR ALZHEIMER'S DISEASE

11 Revised Law

12 Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter  
13 applies only to a health benefit plan that:

14 (1) provides coverage for Alzheimer's disease; and

15 (2) is an individual or group policy, contract,  
16 certificate, or evidence of coverage that is delivered or issued  
17 for delivery in this state by an insurer or a group hospital service  
18 corporation operating under Chapter 842. (V.T.I.C. Art. 3.78  
19 (part).)

20 Source Law

21 Art. 3.78. [If] an individual or group policy,  
22 contract, or certificate, or evidence of coverage  
23 providing coverage for Alzheimer's disease is  
24 delivered or issued for delivery in this state by an  
25 insurer, including a group hospital service  
26 corporation under Chapter 20 of this code, and . . . .

27 Revised Law

28 Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health  
29 benefit plan requires demonstrable proof of organic disease or  
30 other proof before the health benefit plan issuer will authorize  
31 payment of benefits for Alzheimer's disease, that proof requirement  
32 is satisfied by a clinical diagnosis of Alzheimer's disease made by  
33 a physician licensed in this state, including a history and  
34 physical, neurological, and psychological or psychiatric  
35 evaluations, and laboratory studies. (V.T.I.C. Art. 3.78 (part).)

36 Source Law

37 Art. 3.78. If [an individual or group policy,

1 contract, or certificate, or evidence of coverage  
2 providing coverage for Alzheimer's disease is  
3 delivered or issued for delivery in this state by an  
4 insurer, including a group hospital service  
5 corporation under Chapter 20 of this code, and] the  
6 policy, contract, certificate, or evidence requires  
7 demonstrable proof of organic disease or other proof  
8 before the insurer will authorize payment of benefits  
9 for Alzheimer's disease, a clinical diagnosis of  
10 Alzheimer's disease by a physician licensed in this  
11 state, including history and physical, neurological,  
12 psychological and/or psychiatric evaluations, and  
13 laboratory studies, shall satisfy the requirement for  
14 demonstrable proof of organic disease or other proof  
15 under the coverage.

16 CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

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28                                CHAPTER 1355.   BENEFITS FOR CERTAIN MENTAL DISORDERS

29                                SUBCHAPTER A.   GROUP HEALTH BENEFIT PLAN COVERAGE

30                                FOR CERTAIN SERIOUS MENTAL ILLNESSES

31                                Revised Law

32                                Sec. 1355.001.   DEFINITIONS.   In this subchapter:

33                                (1)   "Serious mental illness" means the following

34   psychiatric illnesses as defined by the American Psychiatric

1 Association in the Diagnostic and Statistical Manual (DSM):

2 (A) bipolar disorders (hypomanic, manic,  
3 depressive, and mixed);

4 (B) depression in childhood and adolescence;

5 (C) major depressive disorders (single episode  
6 or recurrent);

7 (D) obsessive-compulsive disorders;

8 (E) paranoid and other psychotic disorders;

9 (F) pervasive developmental disorders;

10 (G) schizo-affective disorders (bipolar or  
11 depressive); and

12 (H) schizophrenia.

13 (2) "Small employer" has the meaning assigned by  
14 Section 1501.002. (V.T.I.C. Art. 3.51-14, Secs. 1(1), (3).)

15 Source Law

16 Art. 3.51-14

17 Sec. 1. For purposes of this article:

18 (1) "Serious mental illness" means the  
19 following psychiatric illnesses as defined by the  
20 American Psychiatric Association in the Diagnostic and  
21 Statistical Manual (DSM):

22 (A) schizophrenia;  
23 (B) paranoid and other psychotic  
24 disorders;

25 (C) bipolar disorders (hypomanic,  
26 manic, depressive, and mixed);

27 (D) major depressive disorders  
28 (single episode or recurrent);

29 (E) schizo-affective disorders  
30 (bipolar or depressive);

31 (F) pervasive developmental  
32 disorders;

33 (G) obsessive-compulsive disorders;  
34 and

35 (H) depression in childhood and  
36 adolescence.

37 (3) "Small employer" has the meaning  
38 assigned by Article 26.02 of this code.

39 Revisor's Note

40 Section 1(2), V.T.I.C. Article 3.51-14, defines  
41 "group health benefit plan." The revised law omits the  
42 definition as unnecessary because Section 2 of that  
43 article, revised as Sections 1355.002 and 1355.003,  
44 specifies the types of group health benefit plans to



1       which this subchapter applies, and thus the defined  
2       term is not helpful to the reader. The omitted law  
3       reads:

4                       (2) "Group health benefit plan"  
5       means a plan described by Section 2 of this  
6       article.

7                               Revised Law

8       Sec. 1355.002. APPLICABILITY       OF       SUBCHAPTER. This  
9       subchapter applies only to a group health benefit plan that  
10      provides benefits for medical or surgical expenses incurred as a  
11      result of a health condition, accident, or sickness, including:

12               (1) a group insurance policy, group insurance  
13      agreement, group hospital service contract, or group evidence of  
14      coverage that is offered by:

15                       (A) an insurance company;

16                       (B) a group hospital service corporation  
17      operating under Chapter 842;

18                       (C) a fraternal benefit society operating under  
19      Chapter 885;

20                       (D) a stipulated premium company operating under  
21      Chapter 884; or

22                       (E) a health maintenance organization operating  
23      under Chapter 843; and

24               (2) to the extent permitted by the Employee Retirement  
25      Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan  
26      offered under:

27                       (A) a multiple employer welfare arrangement as  
28      defined by Section 3 of that Act; or

29                       (B) another analogous benefit arrangement.  
30      (V.T.I.C. Art. 3.51-14, Sec. 2(a).)

31                               Source Law

32       Sec. 2. (a) This article applies only to a  
33      group health benefit plan that provides benefits for  
34      medical or surgical expenses incurred as a result of a  
35      health condition, accident, or sickness, including:

36               (1) a group insurance policy or insurance  
37      agreement, a group hospital service contract, or a  
38      group evidence of coverage that is offered by:

1 (A) an insurance company;  
2 (B) a group hospital service  
3 corporation operating under Chapter 20 of this code;  
4 (C) a health maintenance  
5 organization operating under the Texas Health  
6 Maintenance Organization Act (Chapter 20A, Vernon's  
7 Texas Insurance Code);  
8 (D) a fraternal benefit society  
9 operating under Chapter 10 of this code; or  
10 (E) a stipulated premium insurance  
11 company operating under Chapter 22 of this code; and  
12 (2) to the extent permitted by the  
13 Employee Retirement Income Security Act of 1974 (29  
14 U.S.C. Section 1001 et seq.), a group health benefit  
15 plan that is offered under:  
16 (A) a multiple employer welfare  
17 arrangement as defined by Section 3, Employee  
18 Retirement Income Security Act of 1974 (29 U.S.C.  
19 Section 1002); or  
20 (B) another analogous benefit  
21 arrangement.

22 Revised Law

23 Sec. 1355.003. EXCEPTION. (a) This subchapter does not  
24 apply to coverage under:

- 25 (1) a blanket accident and health insurance policy, as  
26 described by Chapter 1251;  
27 (2) a short-term travel policy;  
28 (3) an accident-only policy;  
29 (4) a limited or specified-disease policy that does  
30 not provide benefits for mental health care or similar services;  
31 (5) except as provided by Subsection (b), a plan  
32 offered under Chapter 1551 or Chapter 1601;  
33 (6) a plan offered in accordance with Section  
34 1355.151; or  
35 (7) a Medicare supplement benefit plan, as defined by  
36 Section 1652.002.

37 (b) For the purposes of a plan described by Subsection  
38 (a)(5), "serious mental illness" has the meaning assigned by  
39 Section 1355.001. (V.T.I.C. Art. 3.51-14, Sec. 2(b).)

40 Source Law

- 41 (b) This article does not apply to coverage  
42 under:  
43 (1) a blanket accident and health  
44 insurance policy as that term is defined under Section  
45 2, Article 3.51-6, of this code;  
46 (2) a short-term travel policy;  
47 (3) an accident-only policy;  
48 (4) a limited or specified-disease policy,

1 other than a plan that provides benefits for mental  
2 health care or similar services;

3 (5) with the exception of Section 1 of this  
4 article which shall apply, a plan offered under the  
5 Texas Employees Uniform Group Insurance Benefits Act  
6 (Article 3.50-2, Vernon's Texas Insurance Code) or the  
7 Texas State College and University Employees Uniform  
8 Insurance Benefits Act (Article 3.50-3, Vernon's Texas  
9 Insurance Code);

10 (6) a plan offered under or in accordance  
11 with Article 3.51-5A of this code; or

12 (7) a Medicare supplement policy, as that  
13 term is defined under Section 1(b)(3), Article 3.74,  
14 of this code.

15 Revisor's Note

16 (1) Section 2(b)(5), V.T.I.C. Article 3.51-14,  
17 provides that "Section 1 of this article . . . shall  
18 apply" to a plan offered under V.T.I.C. Article 3.50-2  
19 or 3.50-3, revised as Chapters 1551 and 1601 of this  
20 code. The clear purpose of the quoted language is to  
21 preserve the definition of "serious mental illness"  
22 for the purposes of those plans. The term "small  
23 employer" is not used in Chapter 1551 or 1601, and the  
24 definition of "group health benefit plan" is not  
25 applicable in those chapters. The revised law is  
26 drafted accordingly.

27 (2) Section 2(b)(7), V.T.I.C. Article 3.51-14,  
28 refers to "a Medicare supplement policy, as that term  
29 is defined under Section 1(b)(3), Article 3.74, of  
30 this code." The revised law substitutes "Medicare  
31 supplement benefit plan" because that is the term used  
32 in Section 1652.002, which revises Section 1(b)(3),  
33 V.T.I.C. Article 3.74.

34 Revised Law

35 Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL  
36 ILLNESS. (a) A group health benefit plan:

37 (1) must provide coverage, based on medical necessity,  
38 for not less than the following treatments of serious mental  
39 illness in each calendar year:

40 (A) 45 days of inpatient treatment; and

41 (B) 60 visits for outpatient treatment,

1 including group and individual outpatient treatment;

2 (2) may not include a lifetime limitation on the  
3 number of days of inpatient treatment or the number of visits for  
4 outpatient treatment covered under the plan; and

5 (3) must include the same amount limitations,  
6 deductibles, copayments, and coinsurance factors for serious  
7 mental illness as the plan includes for physical illness.

8 (b) A group health benefit plan issuer:

9 (1) may not count an outpatient visit for medication  
10 management against the number of outpatient visits required to be  
11 covered under Subsection (a)(1)(B); and

12 (2) must provide coverage for an outpatient visit  
13 described by Subsection (a)(1)(B) under the same terms as the  
14 coverage the issuer provides for an outpatient visit for the  
15 treatment of physical illness. (V.T.I.C. Art. 3.51-14, Secs. 3(a),  
16 (b).)

17 Source Law

18 Sec. 3. (a) Except as provided by Section 4 of  
19 this article, a group health benefit plan:

20 (1) must provide coverage, based on  
21 medical necessity, for the following treatment of  
22 serious mental illness in each calendar year:

23 (A) 45 days of inpatient treatment;  
24 and

25 (B) 60 visits for outpatient  
26 treatment, including group and individual outpatient  
27 treatment;

28 (2) may not include a lifetime limit on the  
29 number of days of inpatient treatment or the number of  
30 outpatient visits covered under the plan; and

31 (3) must include the same amount limits,  
32 deductibles, copayments, and coinsurance factors for  
33 serious mental illness as for physical illness.

34 (b) An issuer of a group health benefit plan may  
35 not count toward the number of outpatient visits  
36 required to be covered under Subsection (a)(1) of this  
37 section an outpatient visit for the purpose of  
38 medication management and must cover that outpatient  
39 visit under the same terms and conditions as it covers  
40 outpatient visits for treatment of physical illness.

41 Revised Law

42 Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group  
43 health benefit plan issuer may provide or offer coverage required  
44 by Section 1355.004 through a managed care plan. (V.T.I.C.  
45 Art. 3.51-14, Sec. 3(c).)

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(c) An issuer of a group health benefit plan may provide or offer coverage required under this section through a managed care plan.

Revised Law

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana  
that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law. (V.T.I.C. Art. 3.51-14, Sec. 5.)

## Source Law

Sec. 5. (a) This article may not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness resulting from the use of a controlled substance or marihuana in violation of law.

(b) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

## Revised Law

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage. (V.T.I.C. Art. 3.51-14, Sec. 4.)

## Source Law

Sec. 4. An issuer of a group health benefit plan to a small employer must offer the coverage described in Section 3 of this article but is not required to provide the coverage if the small employer rejects the coverage.

[Sections 1355.008-1355.050 reserved for expansion]

1 SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

2 Revised Law

3 Sec. 1355.051. DEFINITIONS. In this subchapter:

4 (1) "Crisis stabilization unit" means a 24-hour  
5 residential program that provides, usually for a short term,  
6 intensive supervision and highly structured activities to  
7 individuals who demonstrate a moderate to severe acute psychiatric  
8 crisis.

9 (2) "Individual treatment plan" means a treatment plan  
10 with specific attainable goals and objectives that are appropriate  
11 to:

12 (A) the patient; and

13 (B) the program's treatment modality.

14 (3) "Residential treatment center for children and  
15 adolescents" means a child-care institution that:

16 (A) is accredited as a residential treatment  
17 center by:

18 (i) the Council on Accreditation;

19 (ii) the Joint Commission on Accreditation  
20 of Healthcare Organizations; or

21 (iii) the American Association of  
22 Psychiatric Services for Children; and

23 (B) provides residential care and treatment for  
24 emotionally disturbed children and adolescents. (V.T.I.C.  
25 Art. 3.72, Subsec. (a).)

26 Source Law

27 Art. 3.72. (a) In this article:

28 (1) "Crisis stabilization unit" means a  
29 24-hour residential program that is usually short-term  
30 in nature and that provides intensive supervision and  
31 highly structured activities to persons who are  
32 demonstrating an acute demonstrable psychiatric  
33 crisis of moderate to severe proportions.

34 (2) "Residential treatment center for  
35 children and adolescents" means a child-care  
36 institution that provides residential care and  
37 treatment for emotionally disturbed children and  
38 adolescents and that is accredited as a residential  
39 treatment center by the Council on Accreditation, the  
40 Joint Commission on Accreditation of Hospitals, or the  
41 American Association of Psychiatric Services for

1 Children.

2 (3) "Individual treatment plan" means a  
3 treatment plan with specific attainable goals and  
4 objectives appropriate to both the patient and the  
5 treatment modality of the program.

6 Revisor's Note

7 Subsection (a)(2), V.T.I.C. Article 3.72, refers  
8 to the "Joint Commission on Accreditation of  
9 Hospitals." Throughout this chapter, the revised law  
10 substitutes a reference to the "Joint Commission on  
11 Accreditation of Healthcare Organizations" for the  
12 quoted language because that is the proper name of the  
13 organization to which that language refers.

14 Revised Law

15 Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This  
16 subchapter applies to a group health benefit plan that is delivered  
17 or issued for delivery in this state and that is:

18 (1) an accident and health insurance group policy;

19 (2) a group policy issued by a group hospital service  
20 corporation operating under Chapter 842; or

21 (3) a group health care plan provided by a health  
22 maintenance organization operating under Chapter 843. (V.T.I.C.  
23 Art. 3.72, Subsec. (b) (part).)

24 Source Law

25 (b) . . . a group policy of accident and  
26 sickness insurance delivered or issued for delivery to  
27 a person in this state, including a group policy issued  
28 by a group hospital service plan subject to Chapter 20  
29 of this code and a group health care plan provided by a  
30 health maintenance organization under the Texas Health  
31 Maintenance Organization Act (Chapter 20A, Vernon's  
32 Texas Insurance Code), . . . .

33 Revisor's Note

34 (1) Subsection (b), V.T.I.C. Article 3.72,  
35 refers to a "group hospital service plan subject to  
36 Chapter 20 of this code," meaning a corporation  
37 operating under V.T.I.C. Chapter 20, revised as  
38 Chapter 842 of this code. The term most frequently  
39 used to refer to such a corporation is "group hospital  
40 service corporation." Consequently, the revised law

1 substitutes "group hospital service corporation" for  
2 "group hospital service plan" to provide consistent  
3 use of terminology in this code.

4 (2) Subsection (b), V.T.I.C. Article 3.72,  
5 describes a "group policy of accident and sickness  
6 insurance." The revised law substitutes "group health  
7 benefit plan" for "group policy of accident and  
8 sickness insurance" because the term, as described,  
9 includes coverage provided by a health maintenance  
10 organization that is not insurance. Consequently,  
11 "group health benefit plan" is a more accurate term.  
12 The substitution of this term and related changes  
13 necessary to ensure consistent terminology are made  
14 throughout this subchapter.

#### 15 Revised Law

16 Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND  
17 DISORDERS. A group health benefit plan that provides coverage for  
18 treatment of mental or emotional illness or disorder for a covered  
19 individual when the individual is confined in a hospital must also  
20 provide coverage for treatment in a residential treatment center  
21 for children and adolescents or a crisis stabilization unit that is  
22 at least as favorable as the coverage the plan provides for  
23 treatment of mental or emotional illness or disorder in a hospital.  
24 (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

#### 25 Source Law

26 (b) Subject to the conditions of this article,  
27 a . . . plan . . . that provides coverage for  
28 treatment of mental or emotional illness or disorder  
29 for an insured when confined in a hospital must also  
30 include coverage that is not less favorable for  
31 treatment in a residential treatment center for  
32 children and adolescents or from a crisis  
33 stabilization unit.

#### 34 Revised Law

35 Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of  
36 coverage provided under this subchapter may be used only in a  
37 situation in which:



(1) the covered individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

(b) The service for which benefits are to be paid from coverage provided under this subchapter must be:

(1) based on an individual treatment plan for the covered individual; and

(2) provided by a service provider licensed or operated by the appropriate state agency to provide those services.

(c) Benefits under coverage provided under this subchapter are subject to the same benefit maximums, durational limitations, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment under the coverage. (V.T.I.C. Art. 3.72, Subsec. (c).)

## Source Law

(c) Coverage provided under this article is subject to the following conditions:

(1) the benefits provided by this article may be used only in situations in which the insured has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and treatment were not available through a crisis stabilization unit or residential treatment center for children and adolescents;

(2) the services rendered for which benefits are to be paid must be based on an individual treatment plan;

(3) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services; and

(4) the benefits are subject to the same benefit maximums, durational limits, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment.

1                                    Revisor's Note

2                    Subsection (c)(3), V.T.I.C. Article 3.72, refers  
3                    to the "appropriate state agency or board." The  
4                    revised law omits the reference to a state board as  
5                    unnecessary because a state board is included in the  
6                    meaning of "state agency."

7                                    Revised Law

8                    Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A  
9                    RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND  
10                    ADOLESCENTS. (a) Treatment in a residential treatment center for  
11                    children and adolescents must be determined as if necessary care  
12                    and treatment were inpatient care and treatment in a hospital.

13                    (b) For the purposes of determining policy benefits and  
14                    benefit maximums, each two days of treatment in a residential  
15                    treatment center for children and adolescents is the equivalent of  
16                    one day of treatment of mental or emotional illness or disorder in a  
17                    hospital or inpatient program. (V.T.I.C. Art. 3.72, Subsec. (d).)

18                                    Source Law

19                    (d) Treatment in a residential treatment center  
20                    for children and adolescents shall be determined as if  
21                    necessary care and treatment in a residential  
22                    treatment center for children and adolescents were  
23                    inpatient care and treatment in a hospital, and each  
24                    two days of treatment in a residential treatment  
25                    center for children and adolescents will be considered  
26                    equal to one day of treatment of mental or emotional  
27                    illness or disorder in a hospital or inpatient program  
28                    for the purpose of determining policy benefits and  
29                    benefit maximums.

30                                    Revised Law

31                    Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS  
32                    STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit  
33                    must be determined as if necessary care and treatment were  
34                    inpatient care and treatment in a hospital.

35                    (b) For the purposes of determining plan benefits and  
36                    benefit maximums, each two days of treatment in a crisis  
37                    stabilization unit is the equivalent of one day of treatment of  
38                    mental or emotional illness or disorder in a hospital or inpatient  
39                    program.

1 (c) Treatment provided to an individual by a crisis  
2 stabilization unit licensed or certified by the Texas Department of  
3 Mental Health and Mental Retardation shall be reimbursed. (V.T.I.C.  
4 Art. 3.72, Subsec. (e).)

5 Source Law

6 (e) Treatment provided through crisis  
7 stabilization units shall be determined as if  
8 necessary care and treatment through crisis  
9 stabilization units were inpatient care and treatment  
10 in a hospital, and two days in a crisis stabilization  
11 unit are considered equal to one day of treatment of  
12 mental or emotional illness or disorder in a hospital  
13 or inpatient program for the purpose of determining  
14 policy benefits and benefit maximums. Treatment  
15 provided through crisis stabilization units shall be  
16 reimbursed for facilities licensed or certified by the  
17 Texas Department of Mental Health and Mental  
18 Retardation.

19 Revised Law

20 Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF  
21 REIMBURSEMENT. (a) The commissioner shall monitor and review the  
22 minimum ratios of reimbursement for alternative treatments  
23 required by Sections 1355.055 and 1355.056.

24 (b) If the commissioner finds that the limits provided by  
25 this subchapter are creating an artificial increase in the costs of  
26 services, the commissioner by rule may adjust the ratios to the  
27 extent necessary to prevent the artificial increase.

28 (c) Before the commissioner adjusts a ratio under  
29 Subsection (b), the commissioner must give notice and hold a  
30 hearing to:

31 (1) consider information related to the adjustment;  
32 and

33 (2) determine whether the information justifies the  
34 adjustment.

35 (d) The department shall review the reimbursement ratios at  
36 least every two years. (V.T.I.C. Art. 3.72, Subsec. (f) (part).)

37 Source Law

38 (f) The State Board of Insurance shall monitor  
39 and review the minimum ratios of reimbursement  
40 required by Sections (d) and (e) of this article for  
41 alternative treatments, and if the board determines  
42 that the limits provided by this article are creating

1 an artificial rise in costs of services, the board by  
2 rule may adjust the ratios to the extent necessary to  
3 prevent this artificial rise in costs of services.  
4 Before the board adopts a rule adjusting a ratio of  
5 reimbursement, the board shall give notice and hold a  
6 hearing to consider the data relating to the  
7 adjustment and to determine if that data justifies the  
8 adjustment. . . . the board shall make subsequent  
9 reviews of the ratios of reimbursement at least every  
10 two years . . . .

11 Revisor's Note

12 (1) Subsection (f), V.T.I.C. Article 3.72,  
13 refers to "[t]he State Board of Insurance." Chapter  
14 685, Acts of the 73rd Legislature, Regular Session,  
15 1993, abolished the board and transferred its  
16 functions to the commissioner of insurance and the  
17 Texas Department of Insurance. Throughout this  
18 subchapter, references to the board have been changed  
19 appropriately.

20 (2) Subsection (f), V.T.I.C. Article 3.72,  
21 provides that the State Board of Insurance (now Texas  
22 Department of Insurance) must make the first review of  
23 reimbursement ratios before January 1, 1990. The  
24 revised law omits the references to the initial review  
25 because that provision is executed. The omitted law  
26 reads:

27 (f) . . . The first review by the  
28 board of ratios of reimbursement under this  
29 section must be made before January 1, 1990,  
30 and . . . [every two years] after the first  
31 review.

32 Revised Law

33 Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL  
34 HEALTH AND MENTAL RETARDATION. (a) The Texas Department of  
35 Mental Health and Mental Retardation shall assist the department in  
36 carrying out the department's responsibilities under this  
37 subchapter.

38 (b) The department and the Texas Department of Mental Health  
39 and Mental Retardation by rule may adopt a memorandum of  
40 understanding to carry out this subchapter. (V.T.I.C. Art. 3.72,  
41 Subsec. (g).)





1 to Section (F), V.T.I.C. Article 3.70-2, are revised  
2 as Chapter 1201 of this code. Section 1355.103 is  
3 added to indicate the applicability of those general  
4 provisions to this subchapter. For the convenience of  
5 the reader, the revised law includes general  
6 descriptions of some of the provisions of Chapter  
7 1201.

8 Revised Law

9 Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN  
10 PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy  
11 that provides coverage for treatment of mental or emotional illness  
12 or disorder when an individual is confined in a hospital must also  
13 provide coverage for treatment obtained under the direction and  
14 continued medical supervision of a doctor of medicine or doctor of  
15 osteopathy in a psychiatric day treatment facility that provides  
16 organizational structure and individualized treatment plans  
17 separate from an inpatient program.

18 (b) The psychiatric day treatment facility coverage  
19 required by this section may not be less favorable than the hospital  
20 coverage and must be subject to the same durational limits,  
21 deductibles, and coinsurance factors.

22 (c) A group insurance policy subject to this section may  
23 require that:

24 (1) the treatment obtained in a psychiatric day  
25 treatment facility be provided by a facility that treats a patient  
26 for not more than 8 hours in any 24-hour period;

27 (2) the attending physician certify that the treatment  
28 is in lieu of hospitalization; and

29 (3) the psychiatric day treatment facility be  
30 accredited by the Program for Psychiatric Facilities, or its  
31 successor, of the Joint Commission on Accreditation of Healthcare  
32 Organizations. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

33 Source Law

34 (F) A group policy . . . that provides coverage

1 for treatment of mental or emotional illness or  
2 disorder for a person when confined in a hospital must  
3 also provide that coverage, which is not less  
4 favorable, shall be applicable for treatment under the  
5 direction and continued medical supervision of a  
6 doctor of medicine or doctor of osteopathy in a  
7 psychiatric day treatment facility that provides  
8 organizational structure and individualized treatment  
9 plans separate from an in-patient program; subject to  
10 the same durational limits, deductibles, and  
11 coinsurance factors. . . . Any such policy may require  
12 that the treatment must be provided by a day treatment  
13 facility that treats a patient for not more than eight  
14 hours in any 24-hour period, that the attending  
15 physician certifies that such treatment is in lieu of  
16 hospitalization, and that the psychiatric treatment  
17 facility is accredited by the Program for Psychiatric  
18 Facilities, or its successor, of the Joint Commission  
19 on Accreditation of Hospitals. . . .

20 Revised Law

21 Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC  
22 DAY TREATMENT FACILITY. (a) Benefits provided under this  
23 subchapter shall be determined as if necessary care and treatment  
24 in a psychiatric day treatment facility were inpatient care and  
25 treatment in a hospital.

26 (b) For the purpose of determining policy benefits and  
27 benefit maximums, each full day of treatment in a psychiatric day  
28 treatment facility is the equivalent of one-half of one day of  
29 treatment of mental or emotional illness or disorder in a hospital  
30 or inpatient program. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

31 Source Law

32 (F) . . . Any benefits so provided shall be  
33 determined as if necessary care and treatment in a  
34 psychiatric day treatment facility were in-patient  
35 care and treatment in a hospital, and each full day of  
36 treatment in a psychiatric day treatment facility  
37 shall be considered equal to one-half of one day of  
38 treatment of mental or emotional illness or disorder  
39 in a hospital or in-patient program for the purpose of  
40 determining policy benefits and benefit  
41 maximums. . . .

42 Revised Law

43 Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE  
44 BENEFITS. (a) An insurer shall offer, and a policyholder is  
45 entitled to reject, coverage under a group insurance policy for  
46 treatment of mental or emotional illness or disorder when confined  
47 in a hospital or in a psychiatric day treatment facility.

48 (b) A policyholder may select an alternative level of



benefits under the group insurance policy if the alternative level is offered by or negotiated with the insurer.

(c) The alternative level of benefits must provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed the usual and customary charges of the facility. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

#### Source Law

(F) . . . An insurer shall offer and the policyholder shall have the right to reject such coverage for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility or may select an alternative level of benefits thereunder if such coverage is offered by or negotiated with such insurer, service plan corporation or . . . provided, however, any such alternative level of benefits shall provide policy benefits and benefit maximums for treatment in psychiatric day treatment facilities equal to at least one half of that provided for treatment in hospital facilities, but not to exceed the usual and customary charge of the psychiatric day treatment facility. . . .

#### Revisor's Note

Section (F), V.T.I.C. Article 3.70-2, refers to an "insurer" and to an "insurer [or] service plan corporation," meaning a group hospital service corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The portion of Section (F) that is revised as Section 1355.102 provides that Section (F), revised as this subchapter, applies to a group hospital service corporation. For consistency of terminology, the revised law uses the term "insurer" throughout this subchapter.

[Sections 1355.107-1355.150 reserved for expansion]

#### SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

#### Revised Law

Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF CERTAIN COVERAGES. (a) In this section, "serious mental illness"

1 has the meaning assigned by Section 1355.001.

2 (b) A political subdivision that provides group health  
3 insurance coverage, health maintenance organization coverage, or  
4 self-insured health care coverage to the political subdivision's  
5 officers or employees may not contract for or provide coverage that  
6 is less extensive for serious mental illness than the coverage  
7 provided for any other physical illness. (V.T.I.C. Art. 3.51-5A,  
8 Subsecs. (a) (part), (b).)

9 Source Law

10 Art. 3.51-5A. (a) A municipality, county,  
11 school district, district created under Article III,  
12 Section 52, or Article XVI, Section 59, of the Texas  
13 Constitution, or other political subdivision of the  
14 state that provides group health insurance coverage,  
15 health maintenance organization coverage, or  
16 self-insured health care coverage to its officers or  
17 employees or to both its officers and employees may not  
18 contract for or provide coverage that:

19 . . .  
20 (2) is less extensive for serious mental  
21 illness than the coverage provided for any other  
22 physical illness.

23 (b) For purposes of this article, "serious  
24 mental illness" has the meaning assigned by Section 1,  
25 Article 3.51-14, of this code.

26 Revisor's Note

27 Subsection (a), V.T.I.C. Article 3.51-5A, refers  
28 to "[a] municipality, county, school district,  
29 district created under Article III, Section 52, or  
30 Article XVI, Section 59, of the Texas Constitution, or  
31 other political subdivision of the state." The  
32 revised law substitutes the term "political  
33 subdivision" for the quoted language because each type  
34 of entity specified is included in the meaning of  
35 "political subdivision."

36 [Sections 1355.152-1355.200 reserved for expansion]

37 SUBCHAPTER E. BENEFITS FOR TREATMENT BY

38 TAX-SUPPORTED INSTITUTION

39 Revised Law

40 Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER  
41 LAW. The provisions of Chapter 1201, including provisions

1 relating to the applicability, purpose, and enforcement of that  
2 chapter, construction of policies under that chapter, rulemaking  
3 under that chapter, and definitions of terms applicable in that  
4 chapter, apply to this subchapter. (New.)

5 Revisor's Note

6 Section (D), V.T.I.C. Article 3.70-2, was enacted  
7 as an amendment to Chapter 397, Acts of the 54th  
8 Legislature, Regular Session, 1955, published as  
9 Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B,  
10 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9,  
11 3.70-10, and 3.70-11, Vernon's Texas Insurance Code.  
12 The majority of these articles, which include general  
13 provisions applicable to Section (D), V.T.I.C. Article  
14 3.70-2, are revised as Chapter 1201 of this code.  
15 Section 1355.201 is added to indicate the  
16 applicability of those general provisions to this  
17 subchapter. For the convenience of the reader, the  
18 revised law includes general descriptions of some of  
19 the provisions of Chapter 1201.

20 Revised Law

21 Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR  
22 MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED  
23 INSTITUTION. (a) An individual or group accident and health  
24 insurance policy delivered or issued for delivery to a person in  
25 this state that provides coverage for mental illness or mental  
26 retardation may not exclude benefits under that coverage for  
27 support, maintenance, and treatment provided by a tax-supported  
28 institution of this state, or by a community center for mental  
29 health or mental retardation services, that regularly and  
30 customarily charges patients who are not indigent for those  
31 services.

32 (b) In determining whether a patient is not indigent, as  
33 provided by Subchapter B, Chapter 552, Health and Safety Code, a  
34 tax-supported institution of this state or a community center for

1 mental health or mental retardation services shall consider any  
2 insurance policy or policies that provide coverage to the patient  
3 for mental illness or mental retardation. (V.T.I.C. Art. 3.70-2,  
4 Sec. (D).)

5 Source Law

6 (D) No individual policy or group policy of  
7 accident and sickness insurance delivered or issued  
8 for delivery to any person in this state which provides  
9 coverage for mental illness or mental retardation or  
10 both mental illness and mental retardation shall  
11 exclude benefits for the support, maintenance and  
12 treatment of such mental illness or mental retardation  
13 provided by a tax supported institution of the State of  
14 Texas, including community centers for mental health  
15 and mental retardation services, provided charges for  
16 the care or treatment of such mental illness or mental  
17 retardation are regularly and customarily charged to  
18 non-indigent patients by such tax supported  
19 institution. In determining whether or not a patient  
20 is a non-indigent patient, as provided in Chapter 152,  
21 Acts of the 45th Legislature, Regular Session, 1937  
22 (Article 3196a, Vernon's Texas Civil Statutes), such  
23 tax supported institution shall consider any insurance  
24 policy (or policies) which provides coverage for  
25 mental illness or mental retardation or both mental  
26 illness and mental retardation to such patients.

27 Revisor's Note

28 Section (D), V.T.I.C. Article 3.70-2, refers to  
29 "Chapter 152, Acts of the 45th Legislature, Regular  
30 Session, 1937 (Article 3196a, Vernon's Texas Civil  
31 Statutes)." That statute was codified in 1991 as  
32 Subchapter B, Chapter 552, Health and Safety Code, and  
33 the revised law is drafted accordingly.

34 CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

35	Sec. 1356.001. DEFINITION . . . . .	924
36	Sec. 1356.002. APPLICABILITY OF CHAPTER . . . . .	925
37	Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS	
38	OF OTHER LAW . . . . .	926
39	Sec. 1356.004. EXCEPTION. . . . .	926
40	Sec. 1356.005. COVERAGE REQUIRED . . . . .	927

41 CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

42 Revised Law

43 Sec. 1356.001. DEFINITION. In this chapter, "low-dose  
44 mammography" means the x-ray examination of the breast using

1 equipment dedicated specifically for mammography, including an  
2 x-ray tube, filter, compression device, screens, films, and  
3 cassettes, with an average radiation exposure delivery of less than  
4 one rad mid-breast, with two views for each breast. (V.T.I.C.  
5 Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch.  
6 1091.)

7 Source Law

8 (H) In this section, "low-dose mammography"  
9 means the X-ray examination of the breast using  
10 equipment dedicated specifically for mammography,  
11 including the X-ray tube, filter, compression device,  
12 screens, films, and cassettes, with an average  
13 radiation exposure delivery of less than one rad  
14 mid-breast, with two views for each breast. . . .

15 Revised Law

16 Sec. 1356.002. APPLICABILITY OF CHAPTER. This chapter  
17 applies only to a health benefit plan that is delivered, issued for  
18 delivery, or renewed in this state and that is an individual or  
19 group accident and health insurance policy, including a policy  
20 issued by a group hospital service corporation operating under  
21 Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended  
22 Acts 70th Leg., R.S., Ch. 1091.)

23 Source Law

24 (H) . . . Each individual policy or group  
25 policy of accident and sickness insurance . . . that  
26 is delivered, issued for delivery, or renewed in this  
27 state, . . . including policies issued by companies  
28 subject to Chapter 20, Insurance Code, . . . .

29 Revisor's Note

30 (1) Section (H), V.T.I.C. Article 3.70-2, as  
31 amended by Chapter 1091, Acts of the 70th Legislature,  
32 Regular Session, 1987, refers to policies of "accident  
33 and sickness" insurance. For consistency with modern  
34 usage, the revised law substitutes "accident and  
35 health" for "accident and sickness."

36 (2) Section (H), V.T.I.C. Article 3.70-2, as  
37 amended by Chapter 1091, Acts of the 70th Legislature,  
38 Regular Session, 1987, refers to policies issued by  
39 "companies" subject to V.T.I.C. Chapter 20, revised as

Chapter 842. The term most frequently used to describe such a company is "group hospital service corporation." Therefore, the revised law substitutes "group hospital service corporation" for "companies."

Revised Law

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, revised as this chapter. The majority of these articles are revised in this code as Chapter 1201. Section 1356.003 is added to indicate the applicability of those general provisions to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1356.004. EXCEPTION. This chapter does not apply to a plan that provides coverage only for a specified disease or for another limited benefit. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . [Each individual policy or group policy of accident and sickness insurance . . . that is delivered, issued for delivery, or renewed in this

state,] except for policies that provide coverage for  
specified disease or other limited benefit coverage  
but . . . .

Revised Law

Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit  
plan that provides coverage to a female who is 35 years of age or  
older must include coverage for an annual screening by low-dose  
mammography for the presence of occult breast cancer.

(b) Coverage required by this section:

(1) may not be less favorable than coverage for other  
radiological examinations under the plan; and

(2) must be subject to the same dollar limits,  
deductibles, and coinsurance factors as coverage for other  
radiological examinations under the plan. (V.T.I.C. Art. 3.70-2,  
Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . [Each individual policy or group  
policy of accident and sickness insurance] that covers  
a female 35 years old or older and [that is delivered,  
issued for delivery, or renewed in this state, except  
for policies that provide coverage for specified  
disease or other limited benefit coverage but  
including policies issued by companies subject to  
Chapter 20, Insurance Code,] must include coverage for  
an annual screening by low-dose mammography for the  
presence of occult breast cancer within the provisions  
of the policy that is not less favorable than for other  
radiological examinations and subject to the same  
dollar limits, deductibles, and co-insurance factors.

CHAPTER 1357. MASTECTOMY

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[Sections 1357.008-1357.050 reserved for expansion]

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY  
AND CERTAIN RELATED PROCEDURES

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CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Revised Law

Sec. 1357.001. DEFINITIONS. In this subchapter:

(1) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy has been performed and surgical reconstruction of a breast on which mastectomy has not been performed.

(2) "Enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53I, Secs. 1(2), (3).)

Source Law

Art. 21.53I  
Sec. 1. In this article:

(2) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

(3) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

(1) Section 1(1), V.T.I.C. Article 21.53I, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1357.002 and



1 1357.003, specifies the types of health benefit plans  
2 to which this subchapter applies, and thus the defined  
3 term is not helpful to the reader. The omitted law  
4 reads:

5 (1) "Health benefit plan" means  
6 a plan described by Section 2 of this  
7 article.

8 (2) Section 1(2), V.T.I.C. Article 21.53I,  
9 refers to a "mastectomy surgery." The revised law  
10 substitutes "mastectomy" for "mastectomy surgery"  
11 because the terms are synonymous, and "mastectomy" is  
12 the term used throughout this chapter.

13 Revised Law

14 Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This  
15 subchapter applies only to a health benefit plan that provides  
16 benefits for medical or surgical expenses incurred as a result of a  
17 health condition, accident, or sickness, including an individual,  
18 group, blanket, or franchise insurance policy or insurance  
19 agreement, a group hospital service contract, or an individual or  
20 group evidence of coverage or similar coverage document that is  
21 offered by:

- 22 (1) an insurance company;
- 23 (2) a group hospital service corporation operating  
24 under Chapter 842;
- 25 (3) a fraternal benefit society operating under  
26 Chapter 885;
- 27 (4) a stipulated premium company operating under  
28 Chapter 884;
- 29 (5) a reciprocal exchange operating under Chapter 942;
- 30 (6) a health maintenance organization operating under  
31 Chapter 843;
- 32 (7) a multiple employer welfare arrangement that holds  
33 a certificate of authority under Chapter 846; or
- 34 (8) an approved nonprofit health corporation that  
35 holds a certificate of authority under Chapter 844. (V.T.I.C.

Art. 21.53I, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 20 of this code;
- (3) a fraternal benefit society operating under Chapter 10 of this code;
- (4) a stipulated premium insurance company operating under Chapter 22 of this code;
- (5) a reciprocal exchange operating under Chapter 19 of this code;
- (6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or
- (8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.53I, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner" under Article 21.52F of this code. The revised law omits the quoted language as unnecessary because Article 21.52F, revised as Chapter 844 of this code, requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1357.003. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
  - (A) only for a specified disease or another limited benefit, other than benefits for cancer;
  - (B) only for accidental death or dismemberment;
  - (C) only for wages or payments in lieu of wages

1 for a period during which an employee is absent from work because of  
2 sickness or injury;

3 (D) only for credit insurance;

4 (E) only for dental or vision care;

5 (F) only for indemnity for hospital confinement;

6 or

7 (G) as a supplement to a liability insurance  
8 policy;

9 (2) a Medicare supplemental policy as defined by  
10 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),  
11 as amended;

12 (3) a workers' compensation insurance policy;

13 (4) medical payment insurance coverage provided under  
14 a motor vehicle insurance policy; or

15 (5) a long-term care insurance policy, including a  
16 nursing home fixed indemnity policy, unless the commissioner  
17 determines that the policy provides benefit coverage so  
18 comprehensive that the policy is a health benefit plan as described  
19 by Section 1357.002. (V.T.I.C. Art. 21.53I, Sec. 2(b).)

20 Source Law

21 (b) This article does not apply to:

22 (1) a plan that provides coverage:

23 (A) only for a specified disease or  
24 other limited benefit except for cancer;

25 (B) only for accidental death or  
26 dismemberment;

27 (C) only for wages or payments in  
28 lieu of wages for a period during which an employee is  
29 absent from work because of sickness or injury;

30 (D) only for credit insurance;

31 (E) only for dental or vision care;

32 (F) only for indemnity for hospital  
33 confinement; or

34 (G) as a supplement to liability  
35 insurance;

36 (2) a Medicare supplemental policy as  
37 defined by Section 1882(g)(1), Social Security Act (42  
38 U.S.C. Section 1395ss), as amended;

39 (3) workers' compensation insurance  
40 coverage;

41 (4) medical payment insurance issued as  
42 part of a motor vehicle insurance policy; or

43 (5) a long-term care policy, including a  
44 nursing home fixed indemnity policy, unless the  
45 commissioner determines that the policy provides  
46 benefit coverage so comprehensive that the policy is a  
47 health benefit plan as described by Subsection (a) of

this section.

Revised Law

Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) Coverage required under this section:

(1) shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;

(2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and

(3) may not be subject to dollar limits other than the lifetime maximum benefits under the plan. (V.T.I.C. Art. 21.53I, Sec. 3.)

## Source Law

Sec. 3. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) The coverage described by this section shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee.

(c) The coverage described by this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other benefits under the health benefit plan.

(d) The benefits required by this subchapter may not be subject to dollar limitations other than the health benefit plan's lifetime maximum benefits.

1 Revised Law

2 Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a  
3 health benefit plan may not:

4 (1) offer a financial incentive for an enrollee to not  
5 receive breast reconstruction or to waive the coverage required  
6 under this subchapter;

7 (2) condition, limit, or deny the eligibility of a  
8 person to enroll in the plan or to renew coverage under the terms of  
9 the plan solely to avoid the requirements of this subchapter; or

10 (3) reduce or limit the reimbursement or amount paid  
11 to, or otherwise penalize, an attending physician or provider or  
12 provide a financial incentive or other benefit to an attending  
13 physician or provider to induce the physician or provider to  
14 provide care to an enrollee in a manner that is inconsistent with  
15 this subchapter.

16 (b) This section does not prevent an issuer of a health  
17 benefit plan from negotiating with a physician or provider the  
18 level and type of reimbursement that the physician or provider will  
19 receive for care provided in accordance with this subchapter.

20 (V.T.I.C. Art. 21.53I, Sec. 4.)

21 Source Law

22 Sec. 4. (a) A health benefit plan may not:

23 (1) offer a financial incentive for a  
24 patient to forgo breast reconstruction or to waive the  
25 coverage required by Section 3 of this article;

26 (2) condition, limit, or deny the  
27 eligibility of an enrollee to enroll in the health  
28 benefit plan or to renew coverage under the terms of  
29 the plan solely for the purpose of avoiding the  
30 requirements of this article; or

31 (3) reduce or limit the reimbursement or  
32 payment of, or otherwise penalize, an attending  
33 physician or provider or provide financial incentives  
34 or other benefits to an attending physician or  
35 provider to induce the physician or provider to  
36 provide care to an enrollee in a manner inconsistent  
37 with this article.

38 (b) This section may not be construed to prevent  
39 a health benefit plan from negotiating with a  
40 physician or provider the level and type of  
41 reimbursement that physician or provider will receive  
42 for care provided in accordance with this article.

43 Revised Law

44 Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a

1 health benefit plan that provides coverage under this subchapter  
2 shall provide to each enrollee notice of the availability of the  
3 coverage.

4 (b) The notice must be provided in accordance with rules  
5 adopted by the commissioner. (V.T.I.C. Art. 21.53I, Sec. 5.)

6 Source Law

7 Sec. 5. A health benefit plan that provides  
8 coverage under this article shall provide notice of  
9 the availability of that coverage to each enrollee in  
10 accordance with rules adopted by the commissioner.

11 Revised Law

12 Sec. 1357.007. RULES. The commissioner may adopt rules to  
13 implement this subchapter and to meet the minimum requirements of  
14 federal law. (V.T.I.C. Art. 21.53I, Sec. 7.)

15 Source Law

16 Sec. 7. The commissioner may adopt rules to  
17 implement this article and to meet the minimum  
18 requirements of federal law.

19 Revisor's Note  
20 (End of Subchapter)

21 Section 6, V.T.I.C. Article 21.53I, states that  
22 the article is severable. The revised law omits the  
23 provision as unnecessary because it duplicates Section  
24 311.032, Government Code (Code Construction Act),  
25 applicable to the revised law, and Section 312.013,  
26 Government Code. Those provisions state that a  
27 provision of a statute is severable from each other  
28 provision of the statute that can be given effect. The  
29 omitted law reads:

30 Sec. 6. If any provision of this  
31 article or the application of this article  
32 to any person or circumstance is held  
33 invalid, the invalidity does not affect a  
34 provision or application of this article  
35 that can be given effect without the invalid  
36 provision or application, and to this end,  
37 the provisions of this article are declared  
38 to be severable.

39 [Sections 1357.008-1357.050 reserved for expansion]

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN  
RELATED PROCEDURES

Revised Law

Sec. 1357.051. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.52G, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Art. 21.52G  
Sec. 1. In this article:  
(1) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

Section 1(2), V.T.I.C. Article 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1357.052 and 1357.053, specify the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(2) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

1 (ii) a group hospital service corporation  
2 operating under Chapter 842;

3 (iii) a fraternal benefit society operating  
4 under Chapter 885;

5 (iv) a stipulated premium company operating  
6 under Chapter 884; or

7 (v) a health maintenance organization  
8 operating under Chapter 843; and

9 (B) to the extent permitted by the Employee  
10 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
11 seq.), a health benefit plan that is offered by:

12 (i) a multiple employer welfare arrangement  
13 as defined by Section 3 of that Act; or

14 (ii) another analogous benefit  
15 arrangement;

16 (2) is offered by an approved nonprofit health  
17 corporation that holds a certificate of authority under Chapter  
18 844; or

19 (3) provides coverage only for a specific disease or  
20 condition or for hospitalization. (V.T.I.C. Art. 21.52G, Secs.  
21 2(a), (b), as added Acts 75th Leg., R.S., Ch. 725.)

#### 22 Source Law

23 Sec. 2. (a) This article applies only to a  
24 health benefit plan that:

25 (1) provides benefits for medical or  
26 surgical expenses incurred as a result of a health  
27 condition, accident, or sickness, including:

28 (A) an individual, group, blanket, or  
29 franchise insurance policy or insurance agreement, a  
30 group hospital service contract, or an individual or  
31 group evidence of coverage that is offered by:

32 (i) an insurance company;  
33 (ii) a group hospital service  
34 corporation operating under Chapter 20 of this code;

35 (iii) a fraternal benefit  
36 society operating under Chapter 10 of this code;

37 (iv) a stipulated premium  
38 insurance company operating under Chapter 22 of this  
39 code; or

40 (v) a health maintenance  
41 organization operating under the Texas Health  
42 Maintenance Organization Act (Chapter 20A, Vernon's  
43 Texas Insurance Code); or

44 (B) to the extent permitted by the  
45 Employee Retirement Income Security Act of 1974 (29



U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(b) This article applies to a health benefit plan that provides coverage only for a specific disease or condition or for hospitalization.

#### Revisor's Note

Section 2(a), V.T.I.C. Article 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495(b), Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

#### Revised Law

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

1 (B) for wages or payments in lieu of wages for a  
2 period during which an employee is absent from work because of  
3 sickness or injury; or

4 (C) as a supplement to a liability insurance  
5 policy;

6 (2) a small employer health benefit plan written under  
7 Chapter 1501;

8 (3) a Medicare supplemental policy as defined by  
9 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

10 (4) a workers' compensation insurance policy;

11 (5) medical payment insurance coverage provided under  
12 a motor vehicle insurance policy; or

13 (6) a long-term care insurance policy, including a  
14 nursing home fixed indemnity policy, unless the commissioner  
15 determines that the policy provides benefit coverage so  
16 comprehensive that the policy is a health benefit plan as described  
17 by Section 1357.052. (V.T.I.C. Art. 21.52G, Sec. 2(c), as added  
18 Acts 75th Leg., R.S., Ch. 725.)

19 Source Law

20 (c) This article does not apply to:

21 (1) a plan that provides coverage:

22 (A) only for accidental death or  
23 dismemberment;

24 (B) for wages or payments in lieu of  
25 wages for a period during which an employee is absent  
26 from work because of sickness or injury; or

27 (C) as a supplement to liability  
28 insurance;

29 (2) a small-employer plan written under  
30 Chapter 26 of this code;

31 (3) a Medicare supplemental policy as  
32 defined by Section 1882(g)(1), Social Security Act (42  
33 U.S.C. 1395ss);

34 (4) workers' compensation insurance  
35 coverage;

36 (5) medical payment insurance issued as  
37 part of a motor vehicle insurance policy; or

38 (6) a long-term care policy, including a  
39 nursing home fixed indemnity policy, unless the  
40 commissioner determines that the policy provides  
41 benefit coverage so comprehensive that the policy is a  
42 health benefit plan as described by Subsection (a) of  
43 this section.

44 Revised Law

45 Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit

1 plan that provides coverage for the treatment of breast cancer must  
2 provide to each enrollee coverage for inpatient care for a minimum  
3 of:

4 (1) 48 hours following a mastectomy; and

5 (2) 24 hours following a lymph node dissection for the  
6 treatment of breast cancer.

7 (b) A health benefit plan is not required to provide the  
8 minimum hours of coverage of inpatient care required under  
9 Subsection (a) if the enrollee and the enrollee's attending  
10 physician determine that a shorter period of inpatient care is  
11 appropriate. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th  
12 Leg., R.S., Ch. 725.)

#### 13 Source Law

14 Sec. 3. (a) A health benefit plan that  
15 provides benefits for the treatment of breast cancer  
16 must include coverage for inpatient care for an  
17 enrollee for a minimum of:

18 (1) 48 hours following a mastectomy; and

19 (2) 24 hours following a lymph node  
20 dissection for the treatment of breast cancer.

21 (b) A health benefit plan is not required to  
22 provide the minimum hours of coverage of inpatient  
23 care required under Subsection (a) of this section if  
24 the enrollee and the enrollee's attending physician  
25 determine that a shorter period of inpatient care is  
26 appropriate.

#### 27 Revised Law

28 Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health  
29 benefit plan may not:

30 (1) deny the eligibility or continued eligibility of  
31 an individual to enroll in the plan or renew coverage under the plan  
32 solely to avoid the requirements of this subchapter;

33 (2) provide money payments or rebates to an enrollee  
34 to encourage the enrollee to accept less than the minimum coverage  
35 required under this subchapter;

36 (3) reduce or limit the amount paid to an attending  
37 physician, or otherwise penalize the physician, because the  
38 physician provided care to an enrollee in accordance with this  
39 subchapter; or

40 (4) provide financial or other incentives to an

1 attending physician to encourage the physician to provide care to  
2 an enrollee in a manner inconsistent with this subchapter.  
3 (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch.  
4 725.)

#### 5 Source Law

6 Sec. 4. The issuer of a health benefit plan may  
7 not:

8 (1) deny to an enrollee eligibility or  
9 continued eligibility to enroll or renew coverage  
10 under the terms of the plan solely to avoid the  
11 requirements of this article;

12 (2) provide money payments or rebates to  
13 an enrollee to encourage the enrollee to accept less  
14 than the minimum coverage required under Section 3(a)  
15 of this article;

16 (3) reduce or limit the amount paid to an  
17 attending physician, or otherwise penalize the  
18 physician, because the physician provided care to an  
19 enrollee in accordance with this article; or

20 (4) provide financial or other incentives  
21 to an attending physician to encourage the physician  
22 to provide care to an enrollee in a manner inconsistent  
23 with this article.

#### 24 Revised Law

25 Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a  
26 health benefit plan shall provide to each enrollee written notice  
27 of the coverage required under this subchapter.

28 (b) The notice must be provided in accordance with rules  
29 adopted by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 5, as  
30 added Acts 75th Leg., R.S., Ch. 725.)

#### 31 Source Law

32 Sec. 5. Each health benefit plan shall provide  
33 written notice to each enrollee under the plan  
34 regarding the coverage required by this article. The  
35 notice must be provided in accordance with rules  
36 adopted by the commissioner.

#### 37 Revised Law

38 Sec. 1357.057. RULES. The commissioner shall adopt rules  
39 necessary to administer this subchapter. (V.T.I.C. Art. 21.52G,  
40 Sec. 6, as added Acts 75th Leg., R.S., Ch. 725.)

#### 41 Source Law

42 Sec. 6. The commissioner shall adopt rules as  
43 necessary to administer this article.

1	CHAPTER 1358. DIABETES	
2	SUBCHAPTER A. GUIDELINES FOR DIABETES CARE;	
3	MINIMUM COVERAGE REQUIRED	
4	Sec. 1358.001. DEFINITION . . . . .	941
5	Sec. 1358.002. APPLICABILITY OF SUBCHAPTER . . . . .	942
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7	Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS . . . . .	945
8	Sec. 1358.005. COVERAGE REQUIRED . . . . .	945
9	[Sections 1358.006-1358.050 reserved for expansion]	
10	SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED	
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18	AND SUPPLIES . . . . .	956
19	Sec. 1358.057. RULES . . . . .	956
20	CHAPTER 1358. DIABETES	
21	SUBCHAPTER A. GUIDELINES FOR DIABETES CARE;	
22	MINIMUM COVERAGE REQUIRED	
23	<u>Revised Law</u>	
24	Sec. 1358.001. DEFINITION. In this subchapter, "enrollee"	
25	means an individual entitled to coverage under a health benefit	
26	plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg.,	
27	R.S., Ch. 1285.)	
28	<u>Source Law</u>	
29	Art. 21.53D	
30	Sec. 1. In this article:	
31	(1) "Enrollee" means a person entitled to	
32	coverage under a health benefit plan.	
33	<u>Revisor's Note</u>	
34	Section 1(2), V.T.I.C. Article 21.53D, as added	
35	by Chapter 1285, Acts of the 75th Legislature, Regular	

1 Session, 1997, defines "health benefit plan." The  
2 revised law omits the definition as unnecessary  
3 because Section 2 of that article, revised as Sections  
4 1358.002 and 1358.003, specifies the types of health  
5 benefit plans to which this subchapter applies, and  
6 thus the defined term is not helpful to the reader. The  
7 omitted law reads:

8 (2) "Health benefit plan" means  
9 a plan described by Section 2 of this  
10 article.

11 Revised Law

12 Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This  
13 subchapter applies only to a health benefit plan that provides  
14 benefits for medical or surgical expenses incurred as a result of a  
15 health condition, accident, or sickness, including:

16 (1) an individual, group, blanket, or franchise  
17 insurance policy or insurance agreement, a group hospital service  
18 contract, or an individual or group evidence of coverage that is  
19 offered by:

20 (A) an insurance company;

21 (B) a group hospital service corporation  
22 operating under Chapter 842;

23 (C) a fraternal benefit society operating under  
24 Chapter 885;

25 (D) a stipulated premium company operating under  
26 Chapter 884; or

27 (E) a health maintenance organization operating  
28 under Chapter 843;

29 (2) to the extent permitted by the Employee Retirement  
30 Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a  
31 health benefit plan that is offered by:

32 (A) a multiple employer welfare arrangement as  
33 defined by Section 3 of that Act; or

34 (B) another analogous benefit arrangement; and

35 (3) health and accident coverage provided by a risk

1 pool created under Chapter 172, Local Government Code,  
2 notwithstanding Section 172.014, Local Government Code, or any  
3 other law. (V.T.I.C. Art. 21.53D, Sec. 2(a), as added Acts 75th  
4 Leg., R.S., Ch. 1285.)

5 Source Law

6 Sec. 2. (a) This article applies only to a  
7 health benefit plan that provides benefits for medical  
8 or surgical expenses incurred as a result of a health  
9 condition, accident, or sickness, including:

10 (1) an individual, group, blanket, or  
11 franchise insurance policy or insurance agreement, a  
12 group hospital service contract, or an individual or  
13 group evidence of coverage that is offered by:

14 (A) an insurance company;

15 (B) a group hospital service  
16 corporation operating under Chapter 20 of this code;

17 (C) a fraternal benefit society  
18 operating under Chapter 10 of this code;

19 (D) a stipulated premium insurance  
20 company operating under Chapter 22 of this code; or

21 (E) a health maintenance  
22 organization operating under the Texas Health  
23 Maintenance Organization Act (Chapter 20A, Vernon's  
24 Texas Insurance Code);

25 (2) to the extent permitted by the  
26 Employee Retirement Income Security Act of 1974 (29  
27 U.S.C. Section 1001 et seq.), a health benefit plan  
28 that is offered by:

29 (A) a multiple employer welfare  
30 arrangement as defined by Section 3, Employee  
31 Retirement Income Security Act of 1974 (29 U.S.C.  
32 Section 1002); or

33 (B) another analogous benefit  
34 arrangement; or

35 (3) notwithstanding Section 172.014,  
36 Local Government Code, or any other law, health and  
37 accident coverage provided by a risk pool created  
38 under Chapter 172, Local Government Code.

39 Revised Law

40 Sec. 1358.003. EXCEPTION. This subchapter does not apply  
41 to:

42 (1) a plan that provides coverage:

43 (A) only for a specified disease;

44 (B) only for accidental death or dismemberment;

45 (C) for wages or payments in lieu of wages for a  
46 period during which an employee is absent from work because of  
47 sickness or injury;

48 (D) as a supplement to a liability insurance  
49 policy;

50 (E) only for dental or vision care; or

1 (F) only for indemnity for hospital confinement;  
2 (2) a small employer health benefit plan written under  
3 Chapter 1501;  
4 (3) a Medicare supplemental policy as defined by  
5 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);  
6 (4) a workers' compensation insurance policy;  
7 (5) medical payment insurance coverage provided under  
8 a motor vehicle insurance policy; or  
9 (6) a long-term care insurance policy, including a  
10 nursing home fixed indemnity policy, unless the commissioner  
11 determines that the policy provides benefit coverage so  
12 comprehensive that the policy is a health benefit plan as described  
13 by Section 1358.002. (V.T.I.C. Art. 21.53D, Sec. 2(b), as added  
14 Acts 75th Leg., R.S., Ch. 1285.)

15 Source Law

16 (b) This article does not apply to:  
17 (1) a plan that provides coverage:  
18 (A) only for a specified disease;  
19 (B) only for accidental death or  
20 dismemberment;  
21 (C) for wages or payments in lieu of  
22 wages for a period during which an employee is absent  
23 from work because of sickness or injury;  
24 (D) as a supplement to liability  
25 insurance;  
26 (E) dental or vision care only; or  
27 (F) hospital confinement indemnity  
28 coverage only;  
29 (2) a plan written under Chapter 26 of this  
30 code;  
31 (3) a Medicare supplemental policy as  
32 defined by Section 1882(g)(1), Social Security Act (42  
33 U.S.C. Section 1395ss);  
34 (4) workers' compensation insurance  
35 coverage;  
36 (5) medical payment insurance issued as  
37 part of a motor vehicle insurance policy; or  
38 (6) a long-term care policy, including a  
39 nursing home fixed indemnity policy, unless the  
40 commissioner determines that the policy provides  
41 benefit coverage so comprehensive that the policy is a  
42 health benefit plan as described by Subsection (a) of  
43 this section.

44 Revisor's Note

45 Section 2(b)(2), V.T.I.C. Article 21.53D, as  
46 added by Chapter 1285, Acts of the 75th Legislature,  
47 Regular Session, 1997, refers to "a plan written under



Chapter 26 of this code." The revised law refers to a "small employer health benefit plan written under Chapter 1501." When Article 21.53D was enacted, Chapter 26, codified as Chapter 1501 of this code, addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through the enactment of Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the reference to a "small employer health benefit plan" correctly reflects legislative intent.

#### Revised Law

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes. (V.T.I.C. Art. 21.53D, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1285.)

#### Source Law

Sec. 3. (a) The commissioner, in consultation with the Texas Diabetes Council, shall by rule adopt minimum standards for benefits provided to enrollees with diabetes.

#### Revised Law

Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

(b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan. (V.T.I.C. Art. 21.53D, Secs. 3(b), (c), as added Acts 75th Leg., R.S., Ch. 1285.)

#### Source Law

(b) Each health care benefit plan shall provide benefits for the care required by the minimum

standards adopted under Subsection (a) of this section.

(c) The benefits required under this article may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the applicable deductible, coinsurance, or copayment applicable to other similar benefits provided under the plan.

[Sections 1358.006-1358.050 reserved for expansion]

## SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED

### WITH DIABETES TREATMENT

#### Revised Law

Sec. 1358.051. DEFINITIONS. In this subchapter:

(1) "Diabetes equipment" means:

- (A) blood glucose monitors, including monitors designed to be used by blind individuals;
- (B) insulin pumps and associated appurtenances;
- (C) insulin infusion devices; and
- (D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

- (A) test strips for blood glucose monitors;
- (B) visual reading and urine test strips;
- (C) lancets and lancet devices;
- (D) insulin and insulin analogs;
- (E) injection aids;
- (F) syringes;
- (G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and
- (H) glucagon emergency kits.

(3) "Nutrition counseling" has the meaning assigned by Section 701.002, Occupations Code.

(4) "Qualified enrollee" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

- (A) insulin dependent or noninsulin dependent diabetes;
- (B) elevated blood glucose levels induced by

1 pregnancy; or

2 (C) another medical condition associated with  
3 elevated blood glucose levels. (V.T.I.C. Art. 21.53G, Secs. 1(1),  
4 (2), (4), (5).)

5 Source Law

6 Art. 21.53G

7 Sec. 1. In this article:

8 (1) "Diabetes equipment" means:

9 (A) blood glucose monitors,  
10 including monitors designed to be used by blind  
11 individuals;

12 (B) insulin pumps and associated  
13 appurtenances;

14 (C) insulin infusion devices; and  
15 (D) podiatric appliances for the  
16 prevention of complications associated with diabetes.

17 (2) "Diabetes supplies" means:

18 (A) test strips for blood glucose  
19 monitors;

20 (B) visual reading and urine test  
21 strips;

22 (C) lancets and lancet devices;

23 (D) insulin and insulin analogs;

24 (E) injection aids;

25 (F) syringes;

26 (G) prescriptive and nonprescriptive  
27 oral agents for controlling blood sugar levels; and

28 (H) glucagon emergency kits.

29 (4) "Qualified insured" means an  
30 individual eligible for coverage under a health  
31 benefit plan who has been diagnosed with:

32 (A) insulin dependent or noninsulin  
33 dependent diabetes;

34 (B) elevated blood glucose levels  
35 induced by pregnancy; or

36 (C) another medical condition  
37 associated with elevated blood glucose levels.

38 (5) "Nutrition counseling" has the meaning  
39 assigned by Section 2, Licensed Dietitian Act (Article  
40 4512h, Vernon's Texas Civil Statutes).

41 Revisor's Note

42 (1) Section 1(3), V.T.I.C. Article 21.53G,  
43 defines "health benefit plan." The revised law omits  
44 the definition as unnecessary because Section 2 of  
45 that article, revised as Sections 1358.052 and  
46 1358.053, specifies the types of health benefit plans  
47 to which this subchapter applies, and thus the defined  
48 term is not helpful to the reader. The omitted law  
49 reads:

50 (3) "Health benefit plan" means  
51 a plan described by Section 2 of this

1 article.

2 (2) Section 1(4), V.T.I.C. Article 21.53G,  
3 defines "qualified insured" to include certain  
4 individuals eligible for coverage under a health  
5 benefit plan. "Insured" is a term used in conjunction  
6 with traditional insurance. This subchapter applies  
7 to health benefit plans offered by entities such as  
8 health maintenance organizations that are not  
9 traditional insurers. Consequently, "enrollee" is a  
10 more accurate term than "insured," and the revised law  
11 substitutes "enrollee" for "insured."

12 (3) Section 1(5), V.T.I.C. Article 21.53G,  
13 refers to Section 2, Licensed Dietitian Act (Article  
14 4512h, Vernon's Texas Civil Statutes). That statute  
15 was codified in 1999 as Section 701.002, Occupations  
16 Code. The revised law is drafted accordingly.

17 Revised Law

18 Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This  
19 subchapter applies only to a health benefit plan that:

20 (1) provides benefits for medical or surgical expenses  
21 incurred as a result of a health condition, accident, or sickness,  
22 including:

23 (A) an individual, group, blanket, or franchise  
24 insurance policy or insurance agreement, a group hospital service  
25 contract, or an individual or group evidence of coverage that is  
26 offered by:

- 27 (i) an insurance company;
- 28 (ii) a group hospital service corporation  
29 operating under Chapter 842;
- 30 (iii) a fraternal benefit society operating  
31 under Chapter 885;
- 32 (iv) a stipulated premium company operating  
33 under Chapter 884;
- 34 (v) a reciprocal exchange operating under

Chapter 942; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53G, Sec. 2(a).)

#### Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;  
(ii) a group hospital service corporation operating under Chapter 20 of this code;  
(iii) a fraternal benefit society operating under Chapter 10 of this code;  
(iv) a stipulated premium insurance company operating under Chapter 22 of this code;

(v) a reciprocal exchange operating under Chapter 19 of this code; or

(vi) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

#### Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.53G, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice

1 Act," and holds a certificate of authority "issued by  
2 the commissioner under Article 21.52F." The revised  
3 law omits the reference to certification under Section  
4 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
5 Texas Civil Statutes), which was codified in 1999 in  
6 Chapter 162, Occupations Code, as unnecessary because  
7 V.T.I.C. Article 21.52F, revised as Chapter 844 of  
8 this code, requires a nonprofit corporation to be  
9 certified under that provision as a condition of  
10 holding a certificate of authority. The revised law  
11 also omits as unnecessary the reference to the  
12 commissioner issuing the certificate of authority  
13 because Chapter 844 requires the commissioner to issue  
14 the certificate of authority.

15 Revised Law

16 Sec. 1358.053. EXCEPTION. This subchapter does not apply  
17 to:

- 18 (1) a plan that provides coverage:
- 19 (A) only for a specified disease or another  
20 limited benefit;
- 21 (B) only for accidental death or dismemberment;
- 22 (C) for wages or payments in lieu of wages for a  
23 period during which an employee is absent from work because of  
24 sickness or injury;
- 25 (D) as a supplement to a liability insurance  
26 policy;
- 27 (E) for credit insurance;
- 28 (F) only for dental or vision care; or
- 29 (G) only for indemnity for hospital confinement;
- 30 (2) a small employer health benefit plan written under  
31 Chapter 1501;
- 32 (3) a Medicare supplemental policy as defined by  
33 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- 34 (4) a workers' compensation insurance policy;

1           (5) medical payment insurance coverage provided under  
2 a motor vehicle insurance policy; or

3           (6) a long-term care insurance policy, including a  
4 nursing home fixed indemnity policy, unless the commissioner  
5 determines that the policy provides benefit coverage so  
6 comprehensive that the policy is a health benefit plan as described  
7 by Section 1358.052. (V.T.I.C. Art. 21.53G, Sec. 2(b).)

8                           Source Law

9           (b) This article does not apply to:

10               (1) a plan that provides coverage:

11                       (A) only for a specified disease or  
12 other limited benefit;

13                       (B) only for accidental death or  
14 dismemberment;

15                       (C) for wages or payments in lieu of  
16 wages for a period during which an employee is absent  
17 from work because of sickness or injury;

18                       (D) as a supplement to liability  
19 insurance;

20                       (E) for credit insurance;

21                       (F) only for dental or vision care;

22 or

23                       (G) only for indemnity for hospital  
24 confinement;

25               (2) a small employer plan written under  
26 Chapter 26 of this code;

27               (3) a Medicare supplemental policy as  
28 defined by Section 1882(g)(1), Social Security Act (42  
29 U.S.C. Section 1395ss);

30               (4) workers' compensation insurance  
31 coverage;

32               (5) medical payment insurance issued as  
33 part of a motor vehicle insurance policy; or

34               (6) a long-term care policy, including a  
35 nursing home fixed indemnity policy, unless the  
36 commissioner determines that the policy provides  
37 benefit coverage so comprehensive that the policy is a  
38 health benefit plan as described by Subsection (a) of  
39 this section.

40                           Revised Law

41           Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit  
42 plan that provides coverage for the treatment of diabetes and  
43 conditions associated with diabetes must provide to each qualified  
44 enrollee coverage for:

45               (1) diabetes equipment;

46               (2) diabetes supplies; and

47               (3) diabetes self-management training in accordance  
48 with the requirements of Section 1358.055.

49           (b) A health benefit plan may require a deductible,

1 copayment, or coinsurance for coverage provided under this section.  
2 The amount of the deductible, copayment, or coinsurance may not  
3 exceed the amount of the deductible, copayment, or coinsurance  
4 required for treatment of other analogous chronic medical  
5 conditions. (V.T.I.C. Art. 21.53G, Secs. 3, 6.)

#### 6 Source Law

7 Sec. 3. A health benefit plan that provides  
8 benefits for the treatment of diabetes and associated  
9 conditions must provide coverage to each qualified  
10 insured for:

- 11 (1) diabetes equipment;  
12 (2) diabetes supplies; and  
13 (3) diabetes self-management training  
14 programs.

15 Sec. 6. Benefits required under this article may  
16 be made subject to a deductible, copayment, or  
17 coinsurance requirement. A deductible, copayment, or  
18 coinsurance required by the health benefit plan for  
19 benefits under this article may not exceed the  
20 deductible, copayment, or coinsurance required by the  
21 health benefit plan for treatment of other analogous  
22 chronic medical conditions.

#### 23 Revised Law

24 Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a)  
25 Diabetes self-management training must be provided by a health care  
26 practitioner or provider who is:

27 (1) licensed, registered, or certified in this state  
28 to provide appropriate health care services; and

29 (2) acting within the scope of practice authorized by  
30 the license, registration, or certification.

31 (b) For purposes of this subchapter, "self-management  
32 training" includes:

33 (1) training provided to a qualified enrollee, after  
34 the initial diagnosis of diabetes, in the care and management of  
35 that condition, including nutrition counseling and counseling on  
36 the proper use of diabetes equipment and supplies;

37 (2) additional training authorized on the diagnosis of  
38 a physician or other health care practitioner of a significant  
39 change in the qualified enrollee's symptoms or condition that  
40 requires changes in the qualified enrollee's self-management  
41 regime; and



1           (3) periodic or episodic continuing education  
2 training prescribed by an appropriate health care practitioner as  
3 warranted by the development of new techniques or treatments for  
4 diabetes.

5           (c) If the diabetes self-management training is provided on  
6 the written order of a physician or other health care practitioner,  
7 including a health care practitioner practicing under protocols  
8 jointly developed with a physician, the training must also include:

9                 (1) a diabetes self-management training program  
10 recognized by the American Diabetes Association;

11                (2) diabetes self-management training provided by a  
12 multidisciplinary team:

13                         (A) the nonphysician members of which are  
14 coordinated by:

15                                 (i) a diabetes educator who is certified by  
16 the National Certification Board for Diabetes Educators; or

17                                 (ii) an individual who has completed at  
18 least 24 hours of continuing education that meets guidelines  
19 established by the Texas Board of Health and that includes a  
20 combination of diabetes-related educational principles and  
21 behavioral strategies;

22                         (B) that consists of at least a licensed  
23 dietitian and a registered nurse and may include a pharmacist and a  
24 social worker; and

25                         (C) each member of which, other than a social  
26 worker, has recent didactic and experiential preparation in  
27 diabetes clinical and educational issues as determined by the  
28 member's licensing agency, in consultation with the commissioner of  
29 public health, unless the member's licensing agency, in  
30 consultation with the commissioner of public health, determines  
31 that the core educational preparation for the member's license  
32 includes the skills the member needs to provide diabetes  
33 self-management training;

34           (3) diabetes self-management training provided by a

1 diabetes educator certified by the National Certification Board for  
2 Diabetes Educators; or

3 (4) diabetes self-management training that provides  
4 one or more of the following components:

5 (A) a nutrition counseling component provided by  
6 a licensed dietitian, for which the licensed dietitian shall be  
7 paid;

8 (B) a pharmaceutical component provided by a  
9 pharmacist, for which the pharmacist shall be paid;

10 (C) a component provided by a physician assistant  
11 or registered nurse, for which the physician assistant or  
12 registered nurse shall be paid, except that the physician assistant  
13 or registered nurse may not be paid for providing a nutrition  
14 counseling or pharmaceutical component unless a licensed dietitian  
15 or pharmacist is unavailable to provide that component; or

16 (D) a component provided by a physician.

17 (d) An individual may not provide a component of diabetes  
18 self-management training under Subsection (c)(4) unless:

19 (1) the subject matter of the component is within the  
20 scope of the individual's practice; and

21 (2) the individual meets the education requirements,  
22 as determined by the individual's licensing agency in consultation  
23 with the commissioner of public health. (V.T.I.C. Art. 21.53G,  
24 Sec. 4.)

25 Source Law

26 Sec. 4. (a) Diabetes self-management training  
27 under this article must be provided by a health care  
28 practitioner or provider who is licensed, registered,  
29 or certified in this state to provide appropriate  
30 health care services and who is acting within the scope  
31 of practice authorized by the practitioner's or  
32 provider's license, registration, or certification.  
33 Self-management training includes:

34 (1) training provided to a qualified  
35 insured after the initial diagnosis of diabetes in the  
36 care and management of that condition, including  
37 nutrition counseling and proper use of diabetes  
38 equipment and supplies;

39 (2) additional training authorized on the  
40 diagnosis of a physician or other health care  
41 practitioner of a significant change in the qualified  
42 insured's symptoms or condition that requires changes

1 in the qualified insured's self-management regime; and  
2 (3) periodic or episodic continuing  
3 education training when prescribed by an appropriate  
4 health care practitioner as warranted by the  
5 development of new techniques and treatments for  
6 diabetes.

7 (b) Coverage for diabetes self-management  
8 training provided by a health benefit plan under this  
9 article to a qualified insured must include coverage  
10 for the following, if provided on the written order of  
11 a physician or health care practitioner, including the  
12 written order of a health care practitioner practicing  
13 under protocols jointly developed with a physician:

14 (1) a diabetes self-management training  
15 program recognized by the American Diabetes  
16 Association;

17 (2) diabetes self-management training  
18 given by a multidisciplinary team:

19 (A) the non-physician members of  
20 which are coordinated by:

21 (i) a diabetes educator who is  
22 certified by the National Certification Board for  
23 Diabetes Educators; or

24 (ii) a person who has completed  
25 at least 24 hours of continuing education that meets  
26 guidelines established by the Texas Board of Health  
27 and that includes a combination of diabetes-related  
28 educational principles and behavioral strategies;

29 (B) that consists of at least a  
30 licensed dietitian and a registered nurse and may  
31 include a pharmacist and a social worker; and

32 (C) each member of which, other than  
33 a social worker, has recent didactic and experiential  
34 preparation in diabetes clinical and educational  
35 issues as determined by the member's licensing agency,  
36 in consultation with the commissioner of public  
37 health, unless the member's licensing agency, in  
38 consultation with the commissioner of public health,  
39 determines that the core educational preparation for  
40 the member's license includes the skills the member  
41 needs to provide diabetes self-management training;

42 (3) diabetes self-management training  
43 provided by a diabetes educator certified by the  
44 National Certification Board for Diabetes Educators;  
45 or

46 (4) diabetes self-management training in  
47 which one or more of the following components are  
48 provided:

49 (A) the nutrition counseling  
50 component provided by a licensed dietitian, for which  
51 the licensed dietitian shall be paid;

52 (B) the pharmaceutical component  
53 provided by a pharmacist, for which the pharmacist  
54 shall be paid;

55 (C) any component of the training  
56 provided by a physician assistant or registered nurse,  
57 for which the physician assistant or registered nurse  
58 shall be paid, except that the physician assistant or  
59 registered nurse may not be paid for providing a  
60 nutrition counseling or pharmaceutical component  
61 unless a licensed dietitian or pharmacist is  
62 unavailable to provide that component; or

63 (D) any component of the training  
64 provided by a physician.

65 (c) A person may not provide a component of  
66 diabetes self-management training under Subsection  
67 (b)(4) of this section unless the subject matter of the  
68 component is within the scope of the person's practice

and the person meets the education requirements, as determined by the person's licensing agency, in consultation with the commissioner of public health.

Revised Law

Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND SUPPLIES. A health benefit plan must provide coverage for new or improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate. (V.T.I.C. Art. 21.53G, Sec. 5.)

Source Law

Sec. 5. In addition to the benefits required under Sections 3 and 4 of this article, on the approval of the United States Food and Drug Administration of new or improved diabetes equipment or diabetes supplies, including improved insulin or other prescription drugs, each health benefit plan subject to this article must include coverage of the new or improved equipment or supplies if medically necessary and appropriate as determined by a physician or other health care practitioner.

Revised Law

Sec. 1358.057. RULES. (a) The commissioner shall adopt rules necessary to implement this subchapter.

(b) In adopting rules under this section, the commissioner may consult with the commissioner of public health and other appropriate entities. (V.T.I.C. Art. 21.53G, Sec. 7.)

Source Law

Sec. 7. The commissioner shall adopt rules as necessary for the implementation of this article. The commissioner may consult with the commissioner of public health and other appropriate entities in adopting rules under this section.

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA OR OTHER HERITABLE DISEASES

Sec. 1359.001. DEFINITIONS . . . . . 957

Sec. 1359.002. APPLICABILITY OF CHAPTER . . . . . 957

Sec. 1359.003. COVERAGE REQUIRED . . . . . 958

1 CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH  
2 PHENYLKETONURIA OR OTHER HERITABLE DISEASES

3 Revised Law

4 Sec. 1359.001. DEFINITIONS. In this chapter:

5 (1) "Heritable disease" means an inherited disease  
6 that may result in mental or physical retardation or death.

7 (2) "Phenylketonuria" means an inherited condition  
8 that, if not treated, may cause severe mental retardation.  
9 (V.T.I.C. Art. 3.79, Secs. 1(2), (3).)

10 Source Law

11 Sec. 1. In this article:

12 (2) "Heritable disease" means an inherited  
13 disease that may result in mental or physical  
14 retardation or death.

15 (3) "Phenylketonuria" means an inherited  
16 condition that may cause severe mental retardation if  
17 not treated.

18 Revised Law

19 Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter  
20 applies only to a group health benefit plan that is a group policy,  
21 contract, or certificate of health insurance or an evidence of  
22 coverage delivered, issued for delivery, or renewed in this state  
23 by:

24 (1) an insurance company;

25 (2) a group hospital service corporation operating  
26 under Chapter 842; or

27 (3) a health maintenance organization operating under  
28 Chapter 843. (V.T.I.C. Art. 3.79, Sec. 1(1).)

29 Source Law

30 Art. 3.79

31 Sec. 1. In this article:

32 (1) "Health insurance policy" means any  
33 group policy, contract, or certificate of health  
34 insurance or evidence of coverage delivered, issued  
35 for delivery, or renewed in this state by an insurance  
36 company, including a group hospital service  
37 corporation under Chapter 20 of this code and a health  
38 maintenance organization under the Texas Health  
39 Maintenance Organization Act (Chapter 20A, Vernon's  
40 Texas Insurance Code).

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Revisor's Note

Section 1(1), V.T.I.C. Article 3.79, defines "health insurance policy." "Insurance policy" is a term used in conjunction with traditional insurance. Included in the definition of "health insurance policy" are evidences of coverage issued by health maintenance organizations. The coverage provided by this type of document is not insurance coverage, and this type of coverage document is not typically described as an "insurance policy." Therefore, "group health benefit plan" is a more accurate term than "health insurance policy," and the revised law substitutes "group health benefit plan" for "health insurance policy."

Revised Law

Sec. 1359.003. COVERAGE REQUIRED. (a) A group health benefit plan must provide coverage for formulas necessary to treat phenylketonuria or a heritable disease.

(b) The group health benefit plan must provide the coverage to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician. (V.T.I.C. Art. 3.79, Sec. 2.)

Source Law

Sec. 2. Each health insurance policy shall include coverage for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician.

CHAPTER 1360. DIAGNOSIS AND TREATMENT  
AFFECTING TEMPOROMANDIBULAR JOINT

Sec. 1360.001.	DEFINITION . . . . .	959
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1 CHAPTER 1360. DIAGNOSIS AND TREATMENT  
2 AFFECTING TEMPOROMANDIBULAR JOINT

3 Revised Law

4 Sec. 1360.001. DEFINITION. In this chapter,  
5 "temporomandibular joint" includes the jaw and the  
6 craniomandibular joint. (V.T.I.C. Art. 21.53A, Sec. 3(a) (part).)

7 Source Law

8 (a) . . . For purposes of this section, the  
9 temporomandibular joint includes the jaw and the  
10 craniomandibular joint.

11 Revised Law

12 Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter  
13 applies only to a group health benefit plan delivered or issued for  
14 delivery in this state that:

15 (1) provides benefits for dental, medical, or surgical  
16 expenses incurred as a result of a health condition, accident, or  
17 sickness, including:

18 (A) a group, blanket, or franchise insurance  
19 policy or insurance agreement, a group hospital service contract,  
20 or a group evidence of coverage that is offered by:

- 21 (i) an insurance company;  
22 (ii) a group hospital service corporation  
23 operating under Chapter 842;  
24 (iii) a fraternal benefit society operating  
25 under Chapter 885;  
26 (iv) a stipulated premium company operating  
27 under Chapter 884; or  
28 (v) a health maintenance organization  
29 operating under Chapter 843; and

30 (B) to the extent permitted by the Employee  
31 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
32 seq.), a health benefit plan that is offered by:

- 33 (i) a multiple employer welfare arrangement  
34 as defined by Section 3 of that Act;  
35 (ii) an entity not authorized under this

1 code or another insurance law of this state that contracts directly  
2 for health care services on a risk-sharing basis, including a  
3 capitation basis; or

4 (iii) another analogous benefit  
5 arrangement; or

6 (2) is offered by an approved nonprofit health  
7 corporation that holds a certificate of authority under Chapter  
8 844. (V.T.I.C. Art. 21.53A, Secs. 2(a), 3(a) (part).)

9 Source Law

10 Sec. 2. (a) This article applies to a group  
11 health benefit plan that:

12 (1) provides benefits for dental, medical,  
13 or surgical expenses incurred as a result of a health  
14 condition, accident, or sickness, including:

15 (A) a group, blanket, or franchise  
16 insurance policy or insurance agreement, a group  
17 hospital service contract, or a group evidence of  
18 coverage that is offered by:

19 (i) an insurance company;  
20 (ii) a group hospital service  
21 corporation operating under Chapter 20 of this code;

22 (iii) a fraternal benefit  
23 society operating under Chapter 10 of this code;

24 (iv) a stipulated premium  
25 insurance company operating under Chapter 22 of this  
26 code; or

27 (v) a health maintenance  
28 organization operating under the Texas Health  
29 Maintenance Organization Act (Chapter 20A, Vernon's  
30 Texas Insurance Code); or

31 (B) to the extent permitted by the  
32 Employee Retirement Income Security Act of 1974 (29  
33 U.S.C. Section 1001 et seq.), a health benefit plan  
34 that is offered by:

35 (i) a multiple employer welfare  
36 arrangement as defined by Section 3, Employee  
37 Retirement Income Security Act of 1974 (29 U.S.C.  
38 Section 1002);

39 (ii) any other entity not  
40 licensed under this code or another insurance law of  
41 this state that contracts directly for health care  
42 services on a risk-sharing basis, including an entity  
43 that contracts for health care services on a  
44 capitation basis; or

45 (iii) another analogous benefit  
46 arrangement; or

47 (2) is offered by an approved nonprofit  
48 health corporation that is certified under Section  
49 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
50 Texas Civil Statutes), and that holds a certificate of  
51 authority issued by the commissioner under Article  
52 21.52F of this code.

53 Sec. 3. (a) Each health benefit plan delivered  
54 or issued for delivery in this state . . . .



1 Revisor's Note

2 (1) Section 2(a), V.T.I.C. Article 21.53A,  
3 refers to a health benefit plan offered by an entity  
4 that is not "licensed" under the Insurance Code or  
5 another insurance law of this state. The revised law  
6 substitutes "authorized" for "licensed" for  
7 consistency with terminology used throughout this  
8 code.

9 (2) Section 2(a), V.T.I.C. Article 21.53A,  
10 refers to an approved nonprofit health corporation  
11 that is "certified under Section 5.01(a), Medical  
12 Practice Act," and holds a certificate of authority  
13 "issued by the commissioner under Article 21.52F."  
14 The revised law omits the reference to certification  
15 under Section 5.01(a), Medical Practice Act (Article  
16 4495b, Vernon's Texas Civil Statutes), which was  
17 codified in 1999 in Chapter 162, Occupations Code, as  
18 unnecessary because V.T.I.C. Article 21.52F, revised  
19 as Chapter 844 of this code, requires a nonprofit  
20 corporation to be certified under that provision as a  
21 condition of holding a certificate of authority. The  
22 revised law also omits as unnecessary the reference to  
23 the commissioner issuing the certificate of authority  
24 because Chapter 844 requires the commissioner to issue  
25 the certificate of authority.

26 Revised Law

27 Sec. 1360.003. EXCEPTION. This chapter does not apply to:

28 (1) a plan that provides coverage:

- 29 (A) only for a specified disease or another  
30 limited benefit;  
31 (B) only for accidental death or dismemberment;  
32 (C) for wages or payments in lieu of wages for a  
33 period during which an employee is absent from work because of  
34 sickness or injury;

1 (D) as a supplement to a liability insurance  
2 policy;

3 (E) for credit insurance;

4 (F) only for vision care; or

5 (G) only for indemnity for hospital confinement;

6 (2) a Medicare supplemental policy as defined by  
7 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

8 (3) a workers' compensation insurance policy;

9 (4) a small employer health benefit plan written under  
10 Chapter 1501;

11 (5) medical payment insurance coverage provided under  
12 a motor vehicle insurance policy; or

13 (6) a long-term care insurance policy, including a  
14 nursing home fixed indemnity policy, unless the commissioner  
15 determines that the policy provides benefit coverage so  
16 comprehensive that the policy is a health benefit plan as described  
17 by Section 1360.002. (V.T.I.C. Art. 21.53A, Sec. 2(b).)

18 Source Law

19 (b) This article does not apply to:

20 (1) a plan that provides coverage:

21 (A) only for a specified disease or  
22 other limited benefit;

23 (B) only for accidental death or  
24 dismemberment;

25 (C) for wages or payments in lieu of  
26 wages for a period during which an employee is absent  
27 from work because of sickness or injury;

28 (D) as a supplement to liability  
29 insurance;

30 (E) for credit insurance;

31 (F) only for vision care; or

32 (G) only for indemnity for hospital  
33 confinement;

34 (2) a Medicare supplemental policy as  
35 defined by Section 1882(g)(1), Social Security Act (42  
36 U.S.C. Section 1395ss);

37 (3) workers' compensation insurance  
38 coverage;

39 (4) a small employer plan written under  
40 Chapter 26 of this code;

41 (5) medical payment insurance issued as  
42 part of a motor vehicle insurance policy; or

43 (6) a long-term care policy, including a  
44 nursing home fixed indemnity policy, unless the  
45 commissioner determines that the policy provides  
46 benefit coverage so comprehensive that the policy is a  
47 health benefit plan as described by Subsection (a) of  
48 this section.

Revised Law

Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary as a result of:

- (1) an accident;
- (2) a trauma;
- (3) a congenital defect;
- (4) a developmental defect; or
- (5) a pathology.

(b) Coverage required under this section may be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. (V.T.I.C. Art. 21.53A, Secs. 3(a) (part), (b), (c).)

## Source Law

Sec. 3. (a) Each health benefit plan . . . that provides benefits for the medically necessary diagnostic or surgical treatment of skeletal joints must provide comparable coverage as provided by this article for the medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint. . . .

(b) Each health benefit plan shall provide coverage under this article for diagnosis or surgical treatment medically necessary as a result of:

- (1) an accident;
- (2) a trauma;
- (3) a congenital defect;
- (4) a developmental defect; or
- (5) a pathology.

(c) All other provisions generally applicable to surgical treatment under the health benefit plan may be applied to the benefits required under this article, including any requirements for precertification of benefits.

## Revised Law

Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a) This chapter does not require a health benefit plan to provide coverage for dental services if dental services are not otherwise scheduled or provided as part of the coverage provided under the

1 plan.

2 (b) A health benefit plan may not exclude from coverage  
3 under the plan an individual who is unable to undergo dental  
4 treatment in an office setting or under local anesthesia due to a  
5 documented physical, mental, or medical reason as determined by the  
6 individual's physician or by the dentist providing the dental care.  
7 (V.T.I.C. Art. 21.53A, Sec. 4.)

8 Source Law

9 Sec. 4. (a) This article does not require a  
10 health benefit plan to provide dental services if  
11 dental services are not otherwise scheduled or  
12 provided as a part of the benefits covered under the  
13 health benefit plan.

14 (b) A health benefit plan may not exclude from  
15 coverage under the plan an individual who is unable to  
16 undergo dental treatment in an office setting or under  
17 local anesthesia due to a documented physical, mental,  
18 or medical reason as determined by the individual's  
19 physician or the dentist providing the dental care.

20 Revisor's Note  
21 (End of Chapter)

22 Section 1, V.T.I.C. Article 21.53A, defines  
23 "health benefit plan." The revised law omits the  
24 definition as unnecessary because Section 2 of that  
25 article, revised as Sections 1360.002 and 1360.003,  
26 specifies the types of health benefit plans to which  
27 this chapter applies, and thus the defined term is not  
28 helpful to the reader. The omitted law reads:

29 Art. 21.53A  
30 Sec. 1. In this article, "health  
31 benefit plan" means a plan described by  
32 Section 2 of this article.

33 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

34	Sec. 1361.001. DEFINITION . . . . .	964
35	Sec. 1361.002. APPLICABILITY OF CHAPTER . . . . .	965
36	Sec. 1361.003. COVERAGE REQUIRED . . . . .	966

37 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

38 Revised Law

39 Sec. 1361.001. DEFINITION. In this chapter, "qualified  
40 enrollee" means an individual entitled to coverage under a group  
41 health benefit plan who is:

1           (1) a postmenopausal woman who is not receiving  
2 estrogen replacement therapy;

3           (2) an individual with:

4                (A) vertebral abnormalities;

5                (B) primary hyperparathyroidism; or

6                (C) a history of bone fractures; or

7           (3) an individual who is:

8                (A) receiving long-term glucocorticoid therapy;

9 or

10               (B) being monitored to assess the response to or  
11 efficacy of an approved osteoporosis drug therapy. (V.T.I.C.  
12 Art. 21.53C, Secs. (b), (c) (part).)

13                               Source Law

14           (b) "Qualified individual" means:

15                (1) a postmenopausal woman who is not  
16 receiving estrogen replacement therapy;

17                (2) an individual with:

18                       (A) vertebral abnormalities;

19                       (B) primary hyperparathyroidism; or

20                       (C) a history of bone fractures; or

21                (3) an individual who is:

22                       (A) receiving long-term glucocorti  
23 coid therapy; or

24                       (B) being monitored to assess the  
25 response to or efficacy of an approved osteoporosis  
26 drug therapy.

27                (c) [A group health insurance policy must  
28 provide coverage for a qualified individual] covered  
29 by the policy . . . .

30                               Revised Law

31           Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter  
32 applies only to a group health benefit plan delivered, issued for  
33 delivery, or renewed in this state that provides coverage for  
34 medical or surgical expenses incurred as a result of accident or  
35 sickness, including:

36                (1) a group insurance policy;

37                (2) a group contract issued by a group hospital  
38 service corporation operating under Chapter 842; and

39                (3) a group contract issued by a health maintenance  
40 organization operating under Chapter 843. (V.T.I.C. Art. 21.53C,  
41 Sec. (a).)

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1 associated with osteoporosis. (V.T.I.C. Art. 21.53C, Sec. (c)  
2 (part).)

3 Source Law

4 (c) A group health insurance policy must provide  
5 coverage for a qualified individual . . . for  
6 medically accepted bone mass measurement for the  
7 detection of low bone mass and to determine the  
8 person's risk of osteoporosis and fractures associated  
9 with osteoporosis.

10 CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

11	Sec. 1362.001. APPLICABILITY OF CHAPTER . . . . .	967
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16 CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

17 Revised Law

18 Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter  
19 applies only to a health benefit plan that:

20 (1) provides benefits for medical or surgical expenses  
21 incurred as a result of a health condition, accident, or sickness,  
22 including:

23 (A) an individual, group, blanket, or franchise  
24 insurance policy or insurance agreement, a group hospital service  
25 contract, or an individual or group evidence of coverage that is  
26 offered by:

- 27 (i) an insurance company;
- 28 (ii) a group hospital service corporation  
29 operating under Chapter 842;
- 30 (iii) a fraternal benefit society operating  
31 under Chapter 885;
- 32 (iv) a stipulated premium company operating  
33 under Chapter 884; or
- 34 (v) a health maintenance organization  
35 operating under Chapter 843; and

36 (B) to the extent permitted by the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
2 seq.), a health benefit plan that is offered by:

3 (i) a multiple employer welfare arrangement  
4 as defined by Section 3 of that Act; or

5 (ii) another analogous benefit  
6 arrangement;

7 (2) is offered by:

8 (A) an approved nonprofit health corporation  
9 that holds a certificate of authority under Chapter 844; or

10 (B) an entity not authorized under this code or  
11 another insurance law of this state that contracts directly for  
12 health care services on a risk-sharing basis, including a  
13 capitation basis; or

14 (3) provides health and accident coverage through a  
15 risk pool created under Chapter 172, Local Government Code,  
16 notwithstanding Section 172.014, Local Government Code, or any  
17 other law. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th  
18 Leg., R.S., Ch. 1287.)

19 Source Law

20 Sec. 2. (a) This article applies to a health  
21 benefit plan that:

22 (1) provides benefits for medical or  
23 surgical expenses incurred as a result of a health  
24 condition, accident, or sickness, including:

25 (A) an individual, group, blanket, or  
26 franchise insurance policy or insurance agreement, a  
27 group hospital service contract, or an individual or  
28 group evidence of coverage that is offered by:

29 (i) an insurance company;  
30 (ii) a group hospital service  
31 corporation operating under Chapter 20 of this code;

32 (iii) a fraternal benefit  
33 society operating under Chapter 10 of this code;

34 (iv) a stipulated premium  
35 insurance company operating under Chapter 22 of this  
36 code; or

37 (v) a health maintenance  
38 organization operating under the Texas Health  
39 Maintenance Organization Act (Chapter 20A, Vernon's  
40 Texas Insurance Code); and

41 (B) to the extent permitted by the  
42 Employee Retirement Income Security Act of 1974 (29  
43 U.S.C. Section 1001 et seq.), a health benefit plan  
44 that is offered by:

45 (i) a multiple employer welfare  
46 arrangement as defined by Section 3, Employee  
47 Retirement Income Security Act of 1974 (29 U.S.C.  
48 Section 1002); or



1 (ii) another analogous benefit  
2 arrangement;

3 (2) is offered by an approved nonprofit  
4 health corporation that is certified under Section  
5 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
6 Texas Civil Statutes), and that holds a certificate of  
7 authority issued by the commissioner under Article  
8 21.52F of this code;

9 (3) is offered by any other entity not  
10 licensed under this code or another insurance law of  
11 this state that contracts directly for health care  
12 services on a risk-sharing basis, including an entity  
13 that contracts for health care services on a  
14 capitation basis; or

15 (4) notwithstanding Section 172.014,  
16 Local Government Code, or any other law, provides  
17 health and accident coverage through a risk pool  
18 created under Chapter 172, Local Government Code.

19 Revisor's Note

20 (1) Section 2(a), V.T.I.C. Article 21.53F, as  
21 added by Chapter 1287, Acts of the 75th Legislature,  
22 Regular Session, 1997, refers to an approved nonprofit  
23 health corporation that is "certified under Section  
24 5.01(a), Medical Practice Act," and holds a  
25 certificate of authority "issued by the commissioner  
26 under Article 21.52F." The revised law omits the  
27 reference to certification under Section 5.01(a),  
28 Medical Practice Act (Article 4495b, Vernon's Texas  
29 Civil Statutes), which was codified in 1999 in Chapter  
30 162, Occupations Code, as unnecessary because V.T.I.C.  
31 Article 21.52F, revised as Chapter 844 of this code,  
32 requires a nonprofit corporation to be certified under  
33 that provision as a condition of holding a certificate  
34 of authority. The revised law also omits as  
35 unnecessary the reference to the commissioner issuing  
36 the certificate of authority because Chapter 844  
37 requires the commissioner to issue the certificate of  
38 authority.

39 (2) Section 2(a), V.T.I.C. Article 21.53F, as  
40 added by Chapter 1287, Acts of the 75th Legislature,  
41 Regular Session, 1997, refers to a health benefit plan  
42 offered by an entity that is not "licensed" under the  
43 Insurance Code or another insurance law of this state.

1       The revised law substitutes "authorized" for  
2       "licensed" for consistency with terminology used  
3       throughout this code.

4                               Revised Law

5       Sec. 1362.002. EXCEPTION. This chapter does not apply to:

6               (1) a health benefit plan that provides coverage:

7                       (A) only for a specified disease or for another  
8       limited benefit;

9                       (B) only for accidental death or dismemberment;

10                      (C) for wages or payments in lieu of wages for a  
11       period during which an employee is absent from work because of  
12       sickness or injury;

13                      (D) as a supplement to a liability insurance  
14       policy; or

15                      (E) only for indemnity for hospital confinement;

16               (2) a small employer health benefit plan written under  
17       Chapter 1501;

18               (3) a Medicare supplemental policy as defined by  
19       Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

20               (4) a workers' compensation insurance policy;

21               (5) medical payment insurance coverage provided under  
22       a motor vehicle insurance policy; or

23               (6) a long-term care insurance policy, including a  
24       nursing home fixed indemnity policy, unless the commissioner  
25       determines that the policy provides benefit coverage so  
26       comprehensive that the policy is a health benefit plan as described  
27       by Section 1362.001. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added  
28       Acts 75th Leg., R.S., Ch. 1287.)

29                               Source Law

30               (b) This article does not apply to:

31                       (1) a plan that provides coverage:

32                               (A) only for a specified disease or  
33       other limited benefit;

34                               (B) only for accidental death or  
35       dismemberment;

36                               (C) for wages or payments in lieu of  
37       wages for a period during which an employee is absent  
38       from work because of sickness or injury;

1 (D) as a supplement to liability  
2 insurance; or  
3 (E) only for indemnity for hospital  
4 confinement;  
5 (2) a plan written under Chapter 26 of this  
6 code;  
7 (3) a Medicare supplemental policy as  
8 defined by Section 1882(g)(1), Social Security Act (42  
9 U.S.C. Section 1395ss);  
10 (4) workers' compensation insurance  
11 coverage;  
12 (5) medical payment insurance issued as  
13 part of a motor vehicle insurance policy; or  
14 (6) a long-term care policy, including a  
15 nursing home fixed indemnity policy, unless the  
16 commissioner determines that the policy provides  
17 benefit coverage so comprehensive that the policy is a  
18 health benefit plan as described by Subsection (a) of  
19 this section.

#### 20 Revisor's Note

21 Section 2(b)(2), V.T.I.C. Article 21.53F, as  
22 added by Chapter 1287, Acts of the 75th Legislature,  
23 Regular Session, 1997, refers to "a plan written under  
24 Chapter 26 of this code." The revised law refers to a  
25 "small employer health benefit plan written under  
26 Chapter 1501." When Article 21.53F was enacted,  
27 Chapter 26 addressed only benefit plans offered by  
28 small employers. Provisions addressing benefit plans  
29 offered by large employers were later added to Chapter  
30 26 through the enactment of Chapter 955, Acts of the  
31 75th Legislature, Regular Session, 1997.  
32 Consequently, the reference to "a small employer  
33 health benefit plan" correctly reflects legislative  
34 intent.

#### 35 Revised Law

36 Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit  
37 plan that provides coverage for diagnostic medical procedures must  
38 provide to each male enrolled in the plan coverage for expenses for  
39 an annual medically recognized diagnostic examination for the  
40 detection of prostate cancer.

41 (b) Coverage required under this section includes at a  
42 minimum:

43 (1) a physical examination for the detection of

1 prostate cancer; and

2 (2) a prostate-specific antigen test used for the  
3 detection of prostate cancer for each male who:

4 (A) is at least 50 years of age and is  
5 asymptomatic; or

6 (B) is at least 40 years of age and has a family  
7 history of prostate cancer or another prostate cancer risk factor.

8 (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch.  
9 1287.)

10 Source Law

11 Sec. 3. (a) A health benefit plan that  
12 provides benefits for diagnostic medical procedures  
13 must provide coverage for each male enrolled in the  
14 plan for expenses incurred in conducting an annual  
15 medically recognized diagnostic examination for the  
16 detection of prostate cancer.

17 (b) The minimum benefits provided under  
18 Subsection (a) of this section must include:

19 (1) a physical examination for the  
20 detection of prostate cancer; and

21 (2) a prostate-specific antigen test used  
22 for the detection of prostate cancer for each male  
23 enrolled in the plan who is:

24 (A) at least 50 years of age and  
25 asymptomatic; or

26 (B) at least 40 years of age with a  
27 family history of prostate cancer or another prostate  
28 cancer risk factor.

29 Revised Law

30 Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit  
31 plan issuer shall provide to each individual enrolled in the plan  
32 written notice of the coverage required under this chapter.

33 (b) The notice must be provided in accordance with rules  
34 adopted by the commissioner. (V.T.I.C. Art. 21.53F, Sec. 4, as  
35 added Acts 75th Leg., R.S., Ch. 1287.)

36 Source Law

37 Sec. 4. Each health benefit plan shall provide  
38 written notice to each person enrolled in the plan  
39 regarding the coverage required by this article. The  
40 notice must be provided in accordance with rules  
41 adopted by the commissioner.

42 Revised Law

43 Sec. 1362.005. RULES. The commissioner shall adopt rules  
44 necessary to administer this chapter. (V.T.I.C. Art. 21.53F, Sec.

5, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to administer this article.

Revisor's Note  
(End of Chapter)

Section 1, V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1362.001 and 1362.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53F  
Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Sec. 1363.001.	APPLICABILITY OF CHAPTER . . . . .	973
Sec. 1363.002.	EXCEPTION. . . . .	975
Sec. 1363.003.	MINIMUM COVERAGE REQUIRED . . . . .	977
Sec. 1363.004.	NOTICE OF COVERAGE. . . . .	977
Sec. 1363.005.	RULES . . . . .	978

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Revised Law

Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;  
(ii) a group hospital service corporation operating under Chapter 842;  
(iii) a fraternal benefit society operating under Chapter 885;  
(iv) a Lloyd's plan operating under Chapter 941;  
(v) a stipulated premium company operating under Chapter 884; or  
(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or  
(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation operating under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53S, Sec. 2(a).)

#### Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;  
(ii) a group hospital service corporation operating under Chapter 20 of this code;  
(iii) a fraternal benefit society operating under Chapter 10 of this code;  
(iv) a Lloyd's plan operating under Chapter 18 of this code;  
(v) a stipulated premium

1 insurance company operating under Chapter 22 of this  
2 code; or

3 (vi) a health maintenance  
4 organization operating under the Texas Health  
5 Maintenance Organization Act (Chapter 20A, Vernon's  
6 Texas Insurance Code); and

7 (B) to the extent permitted by the  
8 Employee Retirement Income Security Act of 1974 (29  
9 U.S.C. Section 1001 et seq.), a health benefit plan  
10 that is offered by:

11 (i) a multiple employer welfare  
12 arrangement as defined by Section 3, Employee  
13 Retirement Income Security Act of 1974 (29 U.S.C.  
14 Section 1002); or

15 (ii) another analogous benefit  
16 arrangement;

17 (2) is offered by an approved nonprofit  
18 health corporation that is certified under Section  
19 162.001, Occupations Code, and that holds a  
20 certificate of authority issued by the commissioner  
21 under Article 21.52F of this code; or

22 (3) notwithstanding Section 172.014,  
23 Local Government Code, or any other law, provides  
24 health and accident coverage through a risk pool  
25 created under Chapter 172, Local Government Code.

#### 26 Revisor's Note

27 Section 2(a), V.T.I.C. Article 21.53S, refers to  
28 an approved nonprofit health corporation that is  
29 "certified under Section 162.001, Occupations Code,"  
30 and holds a certificate of authority "issued by the  
31 commissioner under Article 21.52F." The revised law  
32 omits the reference in Article 21.53S to certification  
33 under Section 162.001, Occupations Code, as  
34 unnecessary because V.T.I.C. Article 21.52F, revised  
35 as Chapter 844 of this code, requires an approved  
36 nonprofit health corporation to be certified under  
37 Section 162.001, Occupations Code, as a condition of  
38 holding a certificate of authority. The revised law  
39 also omits as unnecessary the reference to the  
40 commissioner's issuing the certificate of authority  
41 because Chapter 844 requires the commissioner to issue  
42 the certificate of authority.

#### 43 Revised Law

44 Sec. 1363.002. EXCEPTION. This chapter does not apply to:

45 (1) a plan that provides coverage:

46 (A) only for a specified disease or other limited

1 benefit;

2 (B) only for accidental death or dismemberment;

3 (C) for wages or payments in lieu of wages for a  
4 period during which an employee is absent from work because of  
5 sickness or injury;

6 (D) as a supplement to a liability insurance  
7 policy; or

8 (E) only for indemnity for hospital confinement;

9 (2) a small employer health benefit plan written under  
10 Chapter 1501;

11 (3) a Medicare supplemental policy as defined by  
12 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),  
13 as amended;

14 (4) a workers' compensation insurance policy;

15 (5) medical payment insurance coverage provided under  
16 a motor vehicle insurance policy; or

17 (6) a long-term care policy, including a nursing home  
18 fixed indemnity policy, unless the commissioner determines that the  
19 policy provides benefit coverage so comprehensive that the policy  
20 is a health benefit plan as described by Section 1363.001.  
21 (V.T.I.C. Art. 21.53S, Sec. 2(b).)

22 Source Law

23 (b) This article does not apply to:

24 (1) a plan that provides coverage:

25 (A) only for a specified disease or  
26 other limited benefit;

27 (B) only for accidental death or  
28 dismemberment;

29 (C) for wages or payments in lieu of  
30 wages for a period during which an employee is absent  
31 from work because of sickness or injury;

32 (D) as a supplement to liability  
33 insurance; or

34 (E) only for indemnity for hospital  
35 confinement;

36 (2) a small employer plan written under  
37 Chapter 26 of this code;

38 (3) a Medicare supplemental policy as  
39 defined by Section 1882(g)(1), Social Security Act (42  
40 U.S.C. Section 1395ss), as amended;

41 (4) workers' compensation insurance  
42 coverage;

43 (5) medical payment insurance issued as  
44 part of a motor vehicle insurance policy; or

45 (6) a long-term care policy, including a



1 nursing home fixed indemnity policy, unless the  
2 commissioner determines that the policy provides  
3 benefit coverage so comprehensive that the policy is a  
4 health benefit plan as described by Subsection (a) of  
5 this section.

6 Revised Law

7 Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health  
8 benefit plan that provides coverage for screening medical  
9 procedures must provide to each individual enrolled in the plan who  
10 is 50 years of age or older and at normal risk for developing colon  
11 cancer coverage for expenses incurred in conducting a medically  
12 recognized screening examination for the detection of colorectal  
13 cancer.

14 (b) The minimum coverage required under this section must  
15 include:

16 (1) a fecal occult blood test performed annually and a  
17 flexible sigmoidoscopy performed every five years; or

18 (2) a colonoscopy performed every 10 years. (V.T.I.C.  
19 Art. 21.53S, Sec. 3.)

20 Source Law

21 Sec. 3. (a) A health benefit plan that  
22 provides benefits for screening medical procedures  
23 must provide coverage for each person enrolled in the  
24 plan who is 50 years of age or older and at normal risk  
25 for developing colon cancer for expenses incurred in  
26 conducting a medically recognized screening  
27 examination for the detection of colorectal cancer.

28 (b) The minimum benefits provided under  
29 Subsection (a) of this section must:

30 (1) include:

31 (A) a fecal occult blood test  
32 performed annually; and

33 (B) a flexible sigmoidoscopy  
34 performed every five years; or

35 (2) include a colonoscopy performed every  
36 10 years.

37 Revised Law

38 Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit  
39 plan issuer shall provide to each individual enrolled in the plan  
40 written notice of the coverage required under this chapter.

41 (b) The notice must be provided in accordance with rules  
42 adopted by the commissioner. (V.T.I.C. Art. 21.53S, Sec. 4.)

43 Source Law

44 Sec. 4. Each health benefit plan shall provide

1 written notice to each person enrolled in the plan  
2 regarding the coverage required by this article. The  
3 notice must be provided in accordance with rules  
4 adopted by the commissioner.

5 Revised Law

6 Sec. 1363.005. RULES. The commissioner shall adopt rules  
7 as necessary to administer this chapter. (V.T.I.C. Art. 21.53S,  
8 Sec. 5.)

9 Source Law

10 Sec. 5. The commissioner shall adopt rules as  
11 necessary to administer this article.

12 Revisor's Note  
13 (End of Chapter)

14 Section 1, V.T.I.C. Article 21.53S, defines  
15 "health benefit plan." The revised law omits the  
16 definition as unnecessary because Section 2 of that  
17 article, revised as Sections 1363.001 and 1363.002,  
18 specifies the types of health benefit plans to which  
19 this chapter applies, and thus the defined term is not  
20 helpful to the reader. The omitted law reads:

21 Art. 21.53S  
22 Sec. 1. In this article, "health  
23 benefit plan" means a plan described by  
24 Section 2 of this article.

25 CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS,  
26 OR HIV-RELATED ILLNESSES

27 SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

28	Sec. 1364.001. APPLICABILITY OF SUBCHAPTER . . . . .	979
29	Sec. 1364.002. EXCEPTION. . . . .	980
30	Sec. 1364.003. PROHIBITION . . . . .	982
31	Sec. 1364.004. RULES . . . . .	982

32 [Sections 1364.005-1364.050 reserved for expansion]

33 SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

34	Sec. 1364.051. DEFINITIONS . . . . .	983
35	Sec. 1364.052. APPLICABILITY OF SUBCHAPTER . . . . .	983
36	Sec. 1364.053. PROHIBITION . . . . .	983

37 [Sections 1364.054-1364.100 reserved for expansion]

1 SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

2 Sec. 1364.101. PROHIBITION ON EXCLUSION OR

3 LIMITATION OF COVERAGES . . . . . 984

4 CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS,

5 OR HIV-RELATED ILLNESSES

6 SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

7 Revised Law

8 Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This

9 subchapter applies only to a group health benefit plan that is

10 delivered, issued for delivery, or renewed and that is:

- 11 (1) a group accident and health insurance policy;
- 12 (2) a group contract issued by a group hospital
- 13 service corporation operating under Chapter 842; or
- 14 (3) a group evidence of coverage issued by a health
- 15 maintenance organization operating under Chapter 843. (V.T.I.C.
- 16 Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch.
- 17 1041, Sec. 14.)

18 Source Law

19 Sec. 3C. [No] group policy of accident, health,

20 or accident and health insurance including group

21 contracts issued by any hospital and medical service

22 plan corporation subject to Chapter 20 of this code and

23 health maintenance organization subject to Chapter 20A

24 of this code . . . delivered or issued for delivery or

25 renewed . . . .

26 Revisor's Note

- 27 (1) Section 3C, V.T.I.C. Article 3.51-6, as
- 28 added by Section 14, Chapter 1041, Acts of the 71st
- 29 Legislature, Regular Session, 1989, refers to a "group
- 30 policy of accident, health, or accident and health
- 31 insurance." The revised law substitutes "group
- 32 accident and health insurance policy" for "group
- 33 policy of accident, health, or accident and health
- 34 insurance" to provide for consistent use of
- 35 terminology throughout this code.
- 36 (2) Section 3C, V.T.I.C. Article 3.51-6, as
- 37 added by Section 14, Chapter 1041, Acts of the 71st

1       Legislature, Regular Session, 1989, refers to a  
2       "hospital and medical service plan corporation"  
3       subject to V.T.I.C. Chapter 20, revised as Chapter 842  
4       of this code. The term most frequently used to  
5       describe such a corporation is "group hospital service  
6       corporation." Consequently, the revised law  
7       substitutes "group hospital service corporation" for  
8       "hospital and medical service plan corporation" to  
9       provide for consistent use of terminology throughout  
10      this code.

11       (3) Section 3C, V.T.I.C. Article 3.51-6, as  
12      added by Section 14, Chapter 1041, Acts of the 71st  
13      Legislature, Regular Session, 1989, refers to group  
14      "contracts" issued by a health maintenance  
15      organization subject to V.T.I.C. Chapter 20A, revised  
16      in relevant part as Chapter 843 of this code. The term  
17      most frequently used to describe the type of coverage  
18      document issued by a health maintenance organization  
19      is "evidence of coverage." Consequently, the revised  
20      law substitutes "evidence of coverage" for "contracts"  
21      to provide for consistent use of terminology  
22      throughout this code.

23                                      Revised Law

24      Sec. 1364.002. EXCEPTION. This subchapter does not apply  
25      to:

26              (1) a credit accident and health insurance policy  
27      subject to Chapter 1153;

28              (2) any group specifically provided for or authorized  
29      by law in existence and covered under a policy filed with the State  
30      Board of Insurance before April 1, 1975;

31              (3) accident or health coverage that is incidental to  
32      any form of a group automobile, casualty, property, workers'  
33      compensation, or employers' liability policy approved by the  
34      department; or

1           (4) any policy or contract of insurance with a state  
2 agency, department, or board providing health services:

3           (A) to eligible individuals under Chapter 32,  
4 Human Resources Code; or

5           (B) under a state plan adopted in accordance with  
6 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section  
7 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

8                           Source Law

9           Sec. 4. The provisions of this article shall not  
10 be applicable to:

11           (1) credit accident and health insurance  
12 policies subject to Article 3.53 of the Insurance  
13 Code, as amended;

14           (2) any group specifically provided for or  
15 authorized by law in existence and covered under a  
16 policy filed with the State Board of Insurance prior to  
17 April 1, 1975;

18           (3) accident and health coverages that are  
19 incidental to any form of group automobile, casualty,  
20 property, or workmen's compensation--employers'  
21 liability policies promulgated or approved by the  
22 State Board of Insurance;

23           (4) any policy or contract of insurance  
24 with a state agency, department, or board providing  
25 health services to all eligible persons under Chapter  
26 32, Human Resources Code, or in accordance with 42  
27 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C.  
28 Section 1397aa et seq., as amended, under a state plan.

29                           Revisor's Note

30           (1) Section 4(1), V.T.I.C. Article 3.51-6,  
31 refers to "Article 3.53 of the Insurance Code, as  
32 amended." The revised law omits "as amended" because  
33 Section 311.027, Government Code (Code Construction  
34 Act), applicable to the revised law, provides that  
35 unless expressly provided otherwise, a reference to  
36 any portion of a statute applies to all reenactments,  
37 revisions, or amendments of the statute.

38           (2) Section 4(3), V.T.I.C. Article 3.51-6,  
39 refers to the State Board of Insurance. Chapter 685,  
40 Acts of the 73rd Legislature, Regular Session, 1993,  
41 abolished the board and transferred its functions to  
42 the commissioner of insurance and the Texas Department  
43 of Insurance. The reference to the board has been

1 changed appropriately.

2 Revised Law

3 Sec. 1364.003. PROHIBITION. A group health benefit plan  
4 may not exclude or deny coverage for:

- 5 (1) human immunodeficiency virus (HIV);  
6 (2) acquired immune deficiency syndrome (AIDS); or  
7 (3) an HIV-related illness. (V.T.I.C. Art. 3.51-6,  
8 Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

9 Source Law

10 Sec. 3C. No group policy [of accident, health,  
11 or accident and health insurance including group  
12 contracts issued by any hospital and medical service  
13 plan corporation subject to Chapter 20 of this code and  
14 health maintenance organization subject to Chapter 20A  
15 of this code] shall be [delivered or issued for  
16 delivery or renewed] that excludes or denies coverage  
17 for HIV, AIDS, or HIV-related illnesses.

18 Revised Law

19 Sec. 1364.004. RULES. The commissioner may adopt rules  
20 necessary to administer this subchapter. A rule adopted under this  
21 section is subject to notice and hearing as provided by Section  
22 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C.  
23 Art. 3.51-6, Sec. 5.)

24 Source Law

25 Sec. 5. The State Board of Insurance is  
26 authorized to issue such rules and regulations as may  
27 be necessary to carry out the various provisions of  
28 this article. Rules and regulations promulgated  
29 pursuant to this article shall be subject to notice and  
30 hearing pursuant to Section 10, Chapter 397, Acts of  
31 the 54th Legislature, Regular Session, 1955 (Article  
32 3.70-10, Vernon's Texas Insurance Code).

33 Revisor's Note

34 Section 5, V.T.I.C. Article 3.51-6, refers to  
35 "rules and regulations." The revised law omits the  
36 reference to "regulations" because under Section  
37 311.005(5), Government Code (Code Construction Act), a  
38 rule is defined to include a regulation. That  
39 definition applies to the revised law.

40 [Sections 1364.005-1364.050 reserved for expansion]

1 SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

2 Revised Law

3 Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS"  
4 and "HIV" have the meanings assigned by Section 81.101, Health and  
5 Safety Code. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

6 Source Law

7 Art. 3.51-6D. (a) [Except as provided by  
8 Subsection (b) of this article, an insurer that  
9 delivers or issues for delivery a policy or contract of  
10 group health insurance in this state, including a  
11 group hospital service corporation under Chapter 20 of  
12 this code, may not cancel during the term of the policy  
13 or contract the coverage of a person covered by that  
14 policy or contract because that person has been  
15 diagnosed as having or has been or is being treated for  
16 HIV or AIDS] as defined by Section 81.101, Health and  
17 Safety Code.

18 Revised Law

19 Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This  
20 subchapter applies to an insurer that delivers or issues for  
21 delivery a group health insurance policy or contract in this state,  
22 including a group hospital service corporation operating under  
23 Chapter 842. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

24 Source Law

25 Art. 3.51-6D. (a) [Except as provided by  
26 Subsection (b) of this article, an insurer] that  
27 delivers or issues for delivery a policy or contract of  
28 group health insurance in this state, including a  
29 group hospital service corporation under Chapter 20 of  
30 this code, [may not cancel during the term of the  
31 policy or contract the coverage of a person covered by  
32 that policy or contract because that person has been  
33 diagnosed as having or has been or is being treated for  
34 HIV or AIDS as defined by Section 81.101, Health and  
35 Safety Code.]

36 Revised Law

37 Sec. 1364.053. PROHIBITION. (a) Except as provided by  
38 Subsection (b), an insurer may not cancel during the term of a group  
39 health insurance policy or contract an individual's coverage  
40 provided by the policy or contract because the individual:

41 (1) has been diagnosed as having AIDS or HIV;

42 (2) has been treated for AIDS or HIV; or

43 (3) is being treated for AIDS or HIV.

44 (b) The insurer may cancel the coverage provided by the

1 policy or contract for fraud or misrepresentation in the obtaining  
2 of coverage by failure to disclose a diagnosis of AIDS or an  
3 HIV-related condition. (V.T.I.C. Art. 3.51-6D, Subsecs. (a)  
4 (part), (b).)

5 Source Law

6 Art. 3.51-6D. (a) Except as provided by  
7 Subsection (b) of this article, an insurer . . . may  
8 not cancel during the term of the policy or contract  
9 the coverage of a person covered by that policy or  
10 contract because that person has been diagnosed as  
11 having or has been or is being treated for HIV or AIDS  
12 . . . .

13 (b) An insurer may cancel coverage under a  
14 policy or contract covered by Subsection (a) of this  
15 article if there was fraud or misrepresentation in  
16 obtaining the coverage by not disclosing a diagnosis  
17 of AIDS and HIV-related conditions.

18 [Sections 1364.054-1364.100 reserved for expansion]

19 SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

20 Revised Law

21 Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF  
22 COVERAGES. A political subdivision that provides group health  
23 insurance coverage, health maintenance organization coverage, or  
24 self-insured health care coverage to the political subdivision's  
25 officers or employees may not contract for or provide coverage that  
26 excludes or limits coverage or services for:

27 (1) acquired immune deficiency syndrome, as defined by  
28 the Centers for Disease Control and Prevention of the United States  
29 Public Health Service; or

30 (2) human immunodeficiency virus infection.  
31 (V.T.I.C. Art. 3.51-5A, Subsec. (a) (part).)

32 Source Law

33 Art. 3.51-5A. (a) A municipality, county,  
34 school district, district created under Article III,  
35 Section 52, or Article XVI, Section 59, of the Texas  
36 Constitution, or other political subdivision of the  
37 state that provides group health insurance coverage,  
38 health maintenance organization coverage, or  
39 self-insured health care coverage to its officers or  
40 employees or to both its officers and employees may not  
41 contract for or provide coverage that:

42 (1) excludes or limits coverage or  
43 services for acquired immune deficiency syndrome, as  
44 defined by the Centers for Disease Control of the  
45 United States Public Health Service, or human  
46 immunodeficiency virus infection; or



. . . .

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.51-5A, refers to "[a] municipality, county, school district, district created under Article III, Section 52, or Article XVI, Section 59, of the Texas Constitution, or other political subdivision of the state." The revised law substitutes the term "political subdivision" for the quoted language because each type of entity specified is included in the meaning of "political subdivision."

(2) Section (a)(1), V.T.I.C. Article 3.51-5A, refers to the "Centers for Disease Control of the United States Public Health Service." The revised law substitutes the current name for these centers, "Centers for Disease Control and Prevention of the United States Public Health Service."

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Sec. 1365.001.	APPLICABILITY OF CHAPTER . . . . .	985
Sec. 1365.002.	APPLICABILITY OF GENERAL PROVISIONS	
	OF OTHER LAW . . . . .	986
Sec. 1365.003.	OFFER OF COVERAGE REQUIRED . . . . .	987
Sec. 1365.004.	RIGHT TO REJECT COVERAGE OR SELECT	
	ALTERNATIVE COVERAGE . . . . .	987

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Revised Law

Sec. 1365.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital and medical coverage on an expense-incurred, service, or prepaid basis, including a group policy, contract, or plan that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842; or

1 (3) a health maintenance organization operating under  
2 Chapter 843. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

3 Source Law

4 (G) Insurers, nonprofit hospital and medical  
5 service plan corporations subject to Chapter 20 of  
6 this code, and health maintenance organizations  
7 transacting health insurance or providing other health  
8 coverage in this state . . . under group policies,  
9 contracts, and plans providing hospital and medical  
10 coverage on an expense incurred, service or prepaid  
11 basis . . . .

12 Revisor's Note

13 Section (G), V.T.I.C. Article 3.70-2, refers to  
14 "nonprofit hospital and medical service plan  
15 corporations" subject to V.T.I.C. Chapter 20, revised  
16 as Chapter 842 of this code. The term most frequently  
17 used to refer to such a corporation is "group hospital  
18 service corporation." Consequently, the revised law  
19 substitutes "group hospital service corporation" for  
20 "nonprofit hospital and medical service plan  
21 corporations" to provide for consistent use of  
22 terminology throughout this code.

23 Revised Law

24 Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER  
25 LAW. The provisions of Chapter 1201, including provisions  
26 relating to the applicability, purpose, and enforcement of that  
27 chapter, construction of policies under that chapter, rulemaking  
28 under that chapter, and definitions of terms applicable in that  
29 chapter, apply to this chapter. (New.)

30 Revisor's Note

31 Chapter 397, Acts of the 54th Legislature,  
32 Regular Session, 1955, published as V.T.I.C. Articles  
33 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,  
34 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and  
35 3.70-11, contains general provisions applicable to  
36 Section (G), V.T.I.C. Article 3.70-2, revised as this  
37 chapter. The majority of these articles are revised in

1       this code as Chapter 1201. Section 1365.002 is added  
2       to indicate the applicability of those general  
3       provisions to this chapter. For the convenience of the  
4       reader, the revised law includes general descriptions  
5       of some of the applicable provisions of Chapter 1201.

6                               Revised Law

7       Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group  
8       health benefit plan issuer shall offer and make available under the  
9       plan coverage for the necessary care and treatment of loss or  
10      impairment of speech or hearing.

11       (b) Coverage required under this section:

12               (1) may not be less favorable than coverage for  
13      physical illness generally under the plan; and

14               (2) must be subject to the same durational limits,  
15      dollar limits, deductibles, and coinsurance factors as coverage for  
16      physical illness generally under the plan. (V.T.I.C. Art. 3.70-2,  
17      Sec. (G) (part).)

18                               Source Law

19       (G) [Insurers, nonprofit hospital and medical  
20      service plan corporations subject to Chapter 20 of  
21      this code, and health maintenance organizations  
22      transacting health insurance or providing other health  
23      coverage in this state] shall offer and make  
24      available, [under group policies, contracts, and plans  
25      providing hospital and medical coverage on an expense  
26      incurred, service or prepaid basis,] benefits for the  
27      necessary care and treatment of loss or impairment of  
28      speech or hearing that are not less favorable than for  
29      physical illness generally, subject to the same  
30      durational limits, dollar limits, deductibles, and  
31      coinsurance factors. . . .

32                               Revised Law

33       Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT  
34      ALTERNATIVE COVERAGE. An offer of coverage required under Section  
35      1365.003 is subject to the right of the group contract holder to  
36      reject the coverage or to select an alternative level of coverage  
37      that is offered by or negotiated with the group health benefit plan  
38      issuer. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

39                               Source Law

40       (G) . . . Such offer of benefits shall be

subject to the right of the group policy or contract holder to reject the coverage or to select any alternative level of benefits if such right is offered by or negotiated with such insurer, service plan corporation, or health maintenance organization.

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

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[Sections 1366.008-1366.050 reserved for expansion]

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CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Revised Law

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for hospital, medical, or surgical expenses incurred as a result of accident or sickness, including a group health insurance policy, health care service contract or plan, or other provision of group health benefits, coverage, or services in

1 this state that is issued, entered into, or provided by:

2 (1) an insurer;

3 (2) a group hospital service corporation operating  
4 under Chapter 842;

5 (3) a health maintenance organization operating under  
6 Chapter 843; or

7 (4) an employer, multiple employer, union,  
8 association, trustee, or other self-funded or self-insured welfare  
9 or benefit plan, program, or arrangement. (V.T.I.C. Art. 3.51-6,  
10 Sec. 3A(a) (part).)

11 Source Law

12 Sec. 3A. (a) All insurers, nonprofit hospital  
13 and medical service plan corporations subject to  
14 Chapter 20 of this code, health maintenance  
15 organizations subject to the Texas Health Maintenance  
16 Organization Act (Chapter 20A, Vernon's Texas  
17 Insurance Code), and all employer, multiple-employer,  
18 union, association, trustee, or other self-funded or  
19 self-insured welfare or benefit plans, programs, or  
20 arrangements that either issue group health insurance  
21 policies, enter into health care service contracts or  
22 plans, or provide for group health benefits, coverage,  
23 or services in this state for hospital, medical, or  
24 surgical expenses incurred as a result of accident or  
25 sickness [shall offer and make available . . .  
26 coverage] . . . .

27 Revisor's Note

28 Section 3A(a), V.T.I.C. Article 3.51-6, refers to  
29 "nonprofit hospital and medical service plan  
30 corporations" subject to V.T.I.C. Chapter 20, revised  
31 as Chapter 842 of this code. The term most frequently  
32 used to refer to such a corporation is "group hospital  
33 service corporation." Consequently, the revised law  
34 substitutes "group hospital service corporation" for  
35 "nonprofit hospital and medical service plan  
36 corporations" to provide for consistent use of  
37 terminology throughout this code.

38 Revised Law

39 Sec. 1366.002. EXCEPTION. This subchapter does not apply  
40 to:

41 (1) a credit accident and health insurance policy

1 subject to Chapter 1153;

2 (2) any group specifically provided for or authorized  
3 by law in existence and covered under a policy filed with the State  
4 Board of Insurance before April 1, 1975;

5 (3) accident and health coverages that are incidental  
6 to any form of a group automobile, casualty, property, workers'  
7 compensation, or employers' liability policy approved by the  
8 commissioner; or

9 (4) any policy or contract of insurance with a state  
10 agency, department, or board providing health services:

11 (A) to eligible individuals under Chapter 32,  
12 Human Resources Code; or

13 (B) under a state plan adopted in accordance with  
14 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section  
15 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

16 Source Law

17 Sec. 4. The provisions of this article shall not  
18 be applicable to:

19 (1) credit accident and health insurance  
20 policies subject to Article 3.53 of the Insurance  
21 Code, as amended;

22 (2) any group specifically provided for or  
23 authorized by law in existence and covered under a  
24 policy filed with the State Board of Insurance prior to  
25 April 1, 1975;

26 (3) accident and health coverages that are  
27 incidental to any form of group automobile, casualty,  
28 property, or workmen's compensation--employers'  
29 liability policies promulgated or approved by the  
30 State Board of Insurance;

31 (4) any policy or contract of insurance  
32 with a state agency, department, or board providing  
33 health services to all eligible persons under Chapter  
34 32, Human Resources Code, or in accordance with 42  
35 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C.  
36 Section 1397aa et seq., as amended, under a state plan.

37 Revisor's Note

38 (1) Section 4(1), V.T.I.C. Article 3.51-6,  
39 refers to "Article 3.53 of the Insurance Code, as  
40 amended." The revised law omits "as amended" because  
41 Section 311.027, Government Code (Code Construction  
42 Act), applicable to the revised law, provides that  
43 unless expressly provided otherwise, a reference to

1 any portion of a statute applies to all reenactments,  
2 revisions, or amendments of the statute.

3 (2) Section 4(3), V.T.I.C. Article 3.51-6,  
4 refers to the State Board of Insurance. Chapter 685,  
5 Acts of the 73rd Legislature, Regular Session, 1993,  
6 abolished the board and transferred its functions to  
7 the commissioner of insurance and the Texas Department  
8 of Insurance. The reference to the board has been  
9 changed appropriately.

10 Revised Law

11 Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject  
12 to this subchapter, an issuer of a group health benefit plan that  
13 provides pregnancy-related benefits for individuals covered under  
14 the plan shall offer and make available to each holder or sponsor of  
15 the plan coverage for services and benefits on an expense incurred,  
16 service, or prepaid basis for outpatient expenses that arise from  
17 in vitro fertilization procedures.

18 (b) Benefits for in vitro fertilization procedures required  
19 under this section must be provided to the same extent as benefits  
20 provided for other pregnancy-related procedures under the plan.  
21 (V.T.I.C. Art. 3.51-6, Secs. 3A(a) (part), (b), (d).)

22 Source Law

23 (a) [All insurers, nonprofit hospital and  
24 medical service plan corporations subject to Chapter  
25 20 of this code, health maintenance organizations  
26 subject to the Texas Health Maintenance Organization  
27 Act (Chapter 20A, Vernon's Texas Insurance Code), and  
28 all employer, multiple-employer, union, association,  
29 trustee, or other self-funded or self-insured welfare  
30 or benefit plans, programs, or arrangements that  
31 either issue group health insurance policies, enter  
32 into health care service contracts or plans, or  
33 provide for group health benefits, coverage, or  
34 services in this state for hospital, medical, or  
35 surgical expenses incurred as a result of accident or  
36 sickness] shall offer and make available to each group  
37 policyholder, contract holder, employer,  
38 multiple-employer, union, association, or trustee  
39 under a group policy, contract, plan, program, or  
40 arrangement that provides hospital, surgical, and  
41 medical benefits, coverage for services and benefits  
42 on an expense incurred, service, or prepaid basis for  
43 out-patient expenses that may arise from in vitro  
44 fertilization procedures, if the group insurance  
45 policy, contract, plan, program, or arrangement

1 otherwise provides pregnancy-related benefits for the  
2 insureds, enrollees, subscribers, employees, members,  
3 or other persons covered under the policy contract,  
4 plan, program, or arrangement.

5 (b) An offer made under Subsection (a) of this  
6 section is subject to this section.

7 (d) Benefits for in vitro fertilization  
8 procedures must be provided to the same extent as the  
9 benefits provided for other pregnancy-related  
10 procedures under the policy, contract, plan, program,  
11 or arrangement.

12 Revisor's Note

13 Section 3A(a), V.T.I.C. Article 3.51-6, requires  
14 an issuer of a group health benefit plan to provide  
15 certain coverage to each "group policyholder, contract  
16 holder, employer, multiple-employer, union,  
17 association, or trustee" under the plan. For drafting  
18 convenience, the revised law substitutes "holder or  
19 sponsor" for the quoted language because the entities  
20 listed are the types of entities that would hold or  
21 sponsor a group health benefit plan to which this  
22 subchapter applies.

23 Revised Law

24 Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer  
25 under Section 1366.003 to provide coverage for in vitro  
26 fertilization procedures must be in writing. (V.T.I.C.  
27 Art. 3.51-6, Sec. 3A(c).)

28 Source Law

29 (c) A rejection of an offer to provide the  
30 coverage for services or benefits provided by  
31 Subsection (a) of this section must be in writing.

32 Revised Law

33 Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The  
34 coverage offered under Section 1366.003 is required only if:

35 (1) the patient for the in vitro fertilization  
36 procedure is an individual covered under the group health benefit  
37 plan;

38 (2) the fertilization or attempted fertilization of  
39 the patient's oocytes is made only with the sperm of the patient's  
40 spouse;



(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine. (V.T.I.C. Art. 3.51-6, Sec. 3A(e).)

1 guidelines for in vitro fertilization clinics or to  
2 the American Fertility Society minimal standards for  
3 programs of in vitro fertilization.

4 Revisor's Note

5 (1) Section 3A(e)(5), V.T.I.C. Article 3.51-6,  
6 refers to the "American College of Obstetric and  
7 Gynecology guidelines for in vitro fertilization  
8 clinics." The revised law omits the quoted language  
9 because the American College of Obstetricians and  
10 Gynecologists (the proper name of "American College of  
11 Obstetric and Gynecology") no longer has guidelines  
12 for in vitro fertilization clinics.

13 (2) Section 3A(e)(5), V.T.I.C. Article 3.51-6,  
14 refers to the "American Fertility Society." The  
15 revised law substitutes "American Society for  
16 Reproductive Medicine" for "American Fertility  
17 Society" because that is now the name of that  
18 organization.

19 Revised Law

20 Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT  
21 REQUIRED TO OFFER COVERAGE. An insurer, health maintenance  
22 organization, or self-insuring employer that is owned by or that is  
23 part of an entity, group, or order that is directly affiliated with  
24 a bona fide religious denomination that includes as an integral  
25 part of its beliefs and practices that in vitro fertilization is  
26 contrary to moral principles that the religious denomination  
27 considers to be an essential part of its beliefs is not required to  
28 offer coverage for in vitro fertilization under Section 1366.003.  
29 (V.T.I.C. Art. 3.51-6, Sec. 3A(f).)

30 Source Law

31 (f) An insurer, health maintenance  
32 organization, or self-insuring employer that is owned  
33 by or that is part of an entity, group, or order that is  
34 directly affiliated with a bona fide religious  
35 denomination that includes as an integral part of its  
36 beliefs and practices that in vitro fertilization is  
37 contrary to moral principles that the religious  
38 denomination considers to be an essential part of its  
39 beliefs is exempt from this section's requirement to  
40 offer coverage for in vitro fertilization.

1                                    Revised Law

2            Sec. 1366.007. RULES. The commissioner may adopt rules  
3 necessary to administer this subchapter. A rule adopted under this  
4 section is subject to notice and hearing as provided by Section  
5 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C.  
6 Art. 3.51-6, Sec. 5.)

7                                    Source Law

8            Sec. 5. The State Board of Insurance is  
9 authorized to issue such rules and regulations as may  
10 be necessary to carry out the various provisions of  
11 this article. Rules and regulations promulgated  
12 pursuant to this article shall be subject to notice and  
13 hearing pursuant to Section 10, Chapter 397, Acts of  
14 the 54th Legislature, Regular Session, 1955 (Article  
15 3.70-10, Vernon's Texas Insurance Code).

16                                  Revisor's Note

17            Section 5, V.T.I.C. Article 3.51-6, refers to  
18 "rules and regulations." The revised law omits the  
19 reference to "regulations" because under Section  
20 311.005(5), Government Code (Code Construction Act), a  
21 rule is defined to include a regulation. That  
22 definition applies to the revised law.

23            [Sections 1366.008-1366.050 reserved for expansion]

24            SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING  
25            BIRTH OF CHILD AND POSTDELIVERY CARE

26                                    Revised Law

27            Sec. 1366.051. SHORT TITLE. This subchapter may be cited  
28 as the Lee Alexandria Hanley Act. (V.T.I.C. Art. 21.53F, Sec. 1, as  
29 added Acts 75th Leg., R.S., Ch. 832.)

30                                    Source Law

31            Art. 21.53F  
32            Sec. 1. This article may be cited as the Lee  
33 Alexandria Hanley Act.

34                                    Revised Law

35            Sec. 1366.052. DEFINITIONS. In this subchapter:

36            (1) "Attending physician" means an obstetrician,  
37 pediatrician, or other physician who attends a woman who has given  
38 birth to a child or who attends a newborn child.

1           (2) "Postdelivery care" means postpartum health care  
2 services provided in accordance with accepted maternal and neonatal  
3 physical assessments. The term includes parent education,  
4 assistance and training in breast-feeding and bottle-feeding, and  
5 the performance of any necessary and appropriate clinical tests.  
6 (V.T.I.C. Art. 21.53F, Secs. 2(1), 5(c) (part), as added Acts 75th  
7 Leg., R.S., Ch. 832.)

8                           Source Law

9           Sec. 2. In this article:

10           (1) "Attending physician" means an  
11 obstetrician, pediatrician, or other physician who  
12 attends a woman who has given birth or who attends the  
13 newborn child.

14           [Sec. 5]

15           (c) For purposes of this section, "postdelivery  
16 care" means postpartum health care services provided  
17 in accordance with accepted maternal and neonatal  
18 physical assessments. The term includes parent  
19 education, assistance and training in breast-feeding  
20 and bottle-feeding, and the performance of any  
21 necessary and appropriate clinical tests. . . .

22                           Revisor's Note

23           Section 2(3), V.T.I.C. Article 21.53F, as added  
24 by Chapter 832, Acts of the 75th Legislature, Regular  
25 Session, 1997, defines "health benefit plan." The  
26 revised law omits the definition as unnecessary  
27 because Section 3 of that article, revised as Sections  
28 1366.053 and 1366.054, specifies the types of health  
29 benefit plans to which this subchapter applies, and  
30 thus the defined term is not helpful to the reader.  
31 The omitted law reads:

32                           (3) "Health benefit plan" means  
33 a plan described by Section 3 of this  
34 article.

35                           Revised Law

36           Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This  
37 subchapter applies only to a health benefit plan that:

38           (1) provides benefits for medical or surgical expenses  
39 incurred as a result of a health condition, accident, or sickness,  
40 including:

1 (A) an individual, group, blanket, or franchise  
2 insurance policy or insurance agreement, a group hospital service  
3 contract, or an individual or group evidence of coverage that is  
4 offered by:

5 (i) an insurance company;

6 (ii) a group hospital service corporation  
7 operating under Chapter 842;

8 (iii) a fraternal benefit society operating  
9 under Chapter 885;

10 (iv) a stipulated premium company operating  
11 under Chapter 884; or

12 (v) a health maintenance organization  
13 operating under Chapter 843; and

14 (B) to the extent permitted by the Employee  
15 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
16 seq.), a health benefit plan that is offered by:

17 (i) a multiple employer welfare arrangement  
18 as defined by Section 3 of that Act;

19 (ii) an entity not authorized under this  
20 code or another insurance law of this state that contracts directly  
21 for health care services on a risk-sharing basis, including a  
22 capitation basis; or

23 (iii) another analogous benefit  
24 arrangement; or

25 (2) is offered by an approved nonprofit health  
26 corporation that holds a certificate of authority under Chapter  
27 844. (V.T.I.C. Art. 21.53F, Sec. 3(a), as added Acts 75th Leg.,  
28 R.S., Ch. 832.)

29 Source Law

30 Sec. 3. (a) This article applies to a health  
31 benefit plan that:

32 (1) provides benefits for medical or  
33 surgical expenses incurred as a result of a health  
34 condition, accident, or sickness, including:

35 (A) an individual, group, blanket, or  
36 franchise insurance policy or insurance agreement, a  
37 group hospital service contract, or an individual or  
38 group evidence of coverage that is offered by:

1 (i) an insurance company;  
2 (ii) a group hospital service  
3 corporation operating under Chapter 20 of this code;  
4 (iii) a fraternal benefit  
5 society operating under Chapter 10 of this code;  
6 (iv) a stipulated premium  
7 insurance company operating under Chapter 22 of this  
8 code; or  
9 (v) a health maintenance  
10 organization operating under the Texas Health  
11 Maintenance Organization Act (Chapter 20A, Vernon's  
12 Texas Insurance Code); or  
13 (B) to the extent permitted by the  
14 Employee Retirement Income Security Act of 1974 (29  
15 U.S.C. Section 1001 et seq.), a health benefit plan  
16 that is offered by:  
17 (i) a multiple employer welfare  
18 arrangement as defined by Section 3, Employee  
19 Retirement Income Security Act of 1974 (29 U.S.C.  
20 Section 1002);  
21 (ii) any other entity not  
22 licensed under this code or another insurance law of  
23 this state that contracts directly for health care  
24 services on a risk-sharing basis, including an entity  
25 that contracts for health care services on a  
26 capitation basis; or  
27 (iii) another analogous benefit  
28 arrangement; or  
29 (2) is offered by an approved nonprofit  
30 health corporation that is certified under Section  
31 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
32 Texas Civil Statutes), and that holds a certificate of  
33 authority issued by the commissioner under Article  
34 21.52F of this code.

35 Revisor's Note

36 (1) Section 3(a), V.T.I.C. Article 21.53F, as  
37 added by Chapter 832, Acts of the 75th Legislature,  
38 Regular Session, 1997, refers to a health benefit plan  
39 offered by an entity that is not "licensed" under the  
40 Insurance Code or another insurance law of this state.  
41 The revised law substitutes "authorized" for  
42 "licensed" for consistency with terminology used  
43 throughout this code.

44 (2) Section 3(a), V.T.I.C. Article 21.53F, as  
45 added by Chapter 832, Acts of the 75th Legislature,  
46 Regular Session, 1997, refers to an approved nonprofit  
47 health corporation that is "certified under Section  
48 5.01(a), Medical Practice Act," and holds a  
49 certificate of authority "issued by the commissioner  
50 under Article 21.52F." The revised law omits the  
51 reference to certification under Section 5.01(a),

1 Medical Practice Act (Article 4495b, Vernon's Texas  
2 Civil Statutes), which was codified in 1999 in Chapter  
3 162, Occupations Code, as unnecessary because V.T.I.C.  
4 Article 21.52F, revised as Chapter 844 of this code,  
5 requires a nonprofit corporation to be certified under  
6 that provision as a condition of holding a certificate  
7 of authority. The revised law also omits as  
8 unnecessary the reference to the commissioner issuing  
9 the certificate of authority because Chapter 844  
10 requires the commissioner to issue the certificate of  
11 authority.

12 Revised Law

13 Sec. 1366.054. EXCEPTION. This subchapter does not apply  
14 to:

15 (1) a plan that provides coverage:

16 (A) only for a specified disease or for another  
17 limited benefit;

18 (B) only for accidental death or dismemberment;

19 (C) for wages or payments in lieu of wages for a  
20 period during which an employee is absent from work because of  
21 sickness or injury;

22 (D) as a supplement to a liability insurance  
23 policy;

24 (E) for credit insurance;

25 (F) only for dental or vision care; or

26 (G) only for indemnity for hospital confinement;

27 (2) a Medicare supplemental policy as defined by  
28 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

29 (3) a workers' compensation insurance policy;

30 (4) medical payment insurance coverage provided under  
31 a motor vehicle insurance policy; or

32 (5) a long-term care insurance policy, including a  
33 nursing home fixed indemnity policy, unless the commissioner  
34 determines that the policy provides benefit coverage so

comprehensive that the policy is a health benefit plan as described by Section 1366.053. (V.T.I.C. Art. 21.53F, Sec. 3(b), as added Acts 75th Leg., R.S., Ch. 832.)

#### Source Law

(b) This article does not apply to:

- (1) a plan that provides coverage:
  - (A) only for a specified disease or other limited benefit;
  - (B) only for accidental death or dismemberment;
  - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
  - (D) as a supplement to liability insurance;
  - (E) for credit insurance;
  - (F) only for dental or vision care;
- or
- (G) only for indemnity for hospital confinement;
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (3) workers' compensation insurance coverage;
- (4) medical payment insurance issued as part of a motor vehicle insurance policy; or
- (5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

#### Revised Law

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

- (1) 48 hours after an uncomplicated vaginal delivery;
- and
- (2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required under Subsection (a) unless:



(1) the attending physician determines that inpatient care is medically necessary; or

(2) the woman requests inpatient care.

(c) For purposes of Subsection (a), the attending physician shall determine whether a delivery is complicated.

(d) This section does not require a woman who is eligible for coverage under a health benefit plan to:

(1) give birth to a child in a hospital or other health care facility; or

(2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 832.)

## Source Law

Sec. 4. (a) A health benefit plan that provides maternity benefits, including benefits for childbirth, must include coverage for inpatient care for a mother and her newborn child in a health care facility for a minimum of:

(1) 48 hours following an uncomplicated vaginal delivery; and

(2) 96 hours following an uncomplicated delivery by caesarean section.

(b) Notwithstanding Subsection (a) of this section, a health benefit plan that provides coverage for in-home postdelivery care to a mother and her newborn child is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) of this section unless that inpatient care is determined to be medically necessary by an attending physician or is requested by the mother.

(c) For purposes of Subsection (a) of this section, the determination as to whether a delivery is complicated shall be made by the attending physician.

(d) This article does not require a mother who is eligible for coverage under a health benefit plan to:

(1) give birth in a hospital or other health care facility; or

(2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child.

## Revised Law

Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED.

(a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section

1 1366.055(a), a health benefit plan must provide to the woman and  
2 child coverage for timely postdelivery care.

3 (b) The timeliness of the postdelivery care shall be  
4 determined in accordance with recognized medical standards for that  
5 care.

6 (c) The postdelivery care may be provided by a physician,  
7 registered nurse, or other appropriate licensed health care  
8 provider.

9 (d) Subject to Subsection (e), the postdelivery care may be  
10 provided at:

- 11 (1) the woman's home;
  - 12 (2) a health care provider's office;
  - 13 (3) a health care facility; or
  - 14 (4) another location determined to be appropriate
- 15 under rules adopted by the commissioner.

16 (e) The coverage required under this section must give the  
17 woman the option to have the care provided in the woman's home.  
18 (V.T.I.C. Art. 21.53F, Secs. 5(a), (b), (c) (part), as added Acts  
19 75th Leg., R.S., Ch. 832.)

#### 20 Source Law

21 Sec. 5. (a) If a decision is made to discharge  
22 a mother or newborn child from inpatient care before  
23 the expiration of the minimum hours of coverage of  
24 inpatient care required under Section 4(a) of this  
25 article, the health benefit plan must provide coverage  
26 for timely postdelivery care. That care may be  
27 provided to the mother and child by a physician,  
28 registered nurse, or other appropriate licensed health  
29 care provider and may be provided at:

- 30 (1) the mother's home, a health care
- 31 provider's office, or a health care facility; or
- 32 (2) another location determined to be
- 33 appropriate under rules adopted by the commissioner.

34 (b) The coverage required under Subsection (a)  
35 of this section must allow the mother the option to  
36 have the care provided in the mother's home.

37 (c) . . . The timeliness of the care shall be  
38 determined in accordance with recognized medical  
39 standards for that care.

#### 40 Revised Law

41 Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health  
42 benefit plan may not:

- 43 (1) modify the terms and conditions of coverage based

1 on a request by an enrollee for less than the minimum coverage  
2 required under Section 1366.055(a);

3 (2) offer to a woman who has given birth to a child a  
4 financial incentive or other compensation the receipt of which is  
5 contingent on the waiver by the woman of the minimum coverage  
6 required under Section 1366.055(a);

7 (3) refuse to accept a physician's recommendation for  
8 inpatient care made in consultation with the woman who has given  
9 birth to a child if the period of inpatient care recommended by the  
10 physician does not exceed the minimum periods recommended in  
11 guidelines for perinatal care developed by:

12 (A) the American College of Obstetricians and  
13 Gynecologists;

14 (B) the American Academy of Pediatrics; or

15 (C) another nationally recognized professional  
16 association of obstetricians and gynecologists or of  
17 pediatricians;

18 (4) reduce payments or other forms of reimbursement  
19 for inpatient care below the usual and customary rate of  
20 reimbursement for that care; or

21 (5) penalize a physician for recommending inpatient  
22 care for a woman or the woman's newborn child by:

23 (A) refusing to permit the physician to  
24 participate as a provider in the health benefit plan;

25 (B) reducing payments made to the physician;

26 (C) requiring the physician to:

27 (i) provide additional documentation; or

28 (ii) undergo additional utilization  
29 review; or

30 (D) imposing other analogous sanctions or  
31 disincentives. (V.T.I.C. Art. 21.53F, Sec. 6, as added Acts 75th  
32 Leg., R.S., Ch. 832.)

33 Source Law

34 Sec. 6. A health benefit plan may not:

1 (1) modify the terms and conditions of  
2 coverage based on the determination by a person  
3 enrolled in the health benefit plan to request less  
4 than the minimum coverage required under Section 4(a)  
5 of this article;

6 (2) offer to the mother of a newborn child  
7 financial incentives or other compensation the receipt  
8 of which is contingent on the waiver by the mother of  
9 the minimum hours of coverage of inpatient care  
10 required under Section 4(a) of this article;

11 (3) refuse to accept a physician's  
12 recommendation for a specified period of inpatient  
13 care made in consultation with the mother of the  
14 newborn child if the period recommended by the  
15 physician does not exceed the minimum periods  
16 recommended in guidelines for perinatal care developed  
17 by the American College of Obstetricians and  
18 Gynecologists, the American Academy of Pediatrics, or  
19 another nationally recognized professional  
20 association of obstetricians and gynecologists or of  
21 pediatricians;

22 (4) reduce payments or other forms of  
23 reimbursement for inpatient care below the usual and  
24 customary rate of reimbursement for that care; or

25 (5) penalize a physician for recommending  
26 inpatient care for a mother or her newborn child by:

27 (A) refusing to allow the physician  
28 to participate as a provider within the health benefit  
29 plan;

30 (B) reducing payments made to the  
31 physician;

32 (C) requiring the physician to  
33 provide additional documentation or undergo  
34 additional utilization review; or

35 (D) imposing other analogous  
36 sanctions or disincentives.

#### 37 Revised Law

38 Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a  
39 health benefit plan shall provide to each individual enrolled in  
40 the plan written notice of the coverage required under this  
41 subchapter.

42 (b) The notice must be provided in accordance with rules  
43 adopted by the commissioner. (V.T.I.C. Art. 21.53F, Secs. 2(2), 7,  
44 as added Acts 75th Leg., R.S., Ch. 832.)

#### 45 Source Law

46 [Sec. 2. In this article:]

47 (2) "Enrollee" means an individual  
48 enrolled in a health benefit plan.

49 Sec. 7. In accordance with rules adopted by the  
50 commissioner, each health benefit plan must provide to  
51 each enrollee under the plan written notice regarding  
52 the coverage required by this article.

#### 53 Revised Law

54 Sec. 1366.059. RULES. The commissioner shall adopt rules

necessary to administer this subchapter. (V.T.I.C. Art. 21.53F,  
Sec. 8, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 8. The commissioner shall adopt rules as  
necessary to administer this article.

CHAPTER 1367. COVERAGE OF CHILDREN

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3 CHAPTER 1367. COVERAGE OF CHILDREN

4 SUBCHAPTER A. NEWBORN CHILDREN

5 Revised Law

6 Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This

7 subchapter applies only to a health benefit plan delivered or

8 issued for delivery in this state that is an individual or group

9 policy of accident and health insurance, including a policy issued

10 by a group hospital service corporation operating under Chapter

11 842. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

12 Source Law

13 (E) [No] individual policy or group policy of

14 accident and sickness insurance, including policies

15 issued by companies subject to Chapter 20, Texas

16 Insurance Code, as amended, delivered or issued for

17 delivery to any person in this state . . . .

18 Revisor's Note

19 (1) Section (E), V.T.I.C. Article 3.70-2,

20 refers to an individual or group policy of "accident

21 and sickness" insurance. For consistency with modern

22 usage, the revised law substitutes "accident and

23 health" for "accident and sickness" throughout this

24 chapter.

25 (2) Section (E), V.T.I.C. Article 3.70-2,

26 refers to "policies issued by companies" subject to

27 V.T.I.C. Chapter 20, revised as Chapter 842 of this

28 code. The term most frequently used to refer to such a

29 company is "group hospital service corporation."

30 Consequently, the revised law substitutes "group

31 hospital service corporation" for "companies" to

32 provide for consistent use of terminology throughout

33 this code.

34 (3) Section (E), V.T.I.C. Article 3.70-2,

35 refers to Chapter 20, Insurance Code, "as amended."

36 The revised law omits the reference to amendments as

unnecessary because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, states that a reference to a statute includes reenactments, revisions, or amendments of that statute.

#### Revised Law

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

#### Revisor's Note

Section (E), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11. The majority of these articles, which include general provisions applicable to Section (E), V.T.I.C. Article 3.70-2, are revised in this code as Chapter 1201. Section 1367.002 is added to indicate the applicability of those general provisions in this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

#### Revised Law

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED. A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not be issued in this state if the plan excludes or limits:

(1) initial coverage of a newborn child for a period of

1 time; or

2 (2) coverage for congenital defects of a newborn  
3 child. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

4 Source Law

5 (E) No [individual policy or group policy of  
6 accident and sickness insurance, including policies  
7 issued by companies subject to Chapter 20, Texas  
8 Insurance Code,] . . . which provides for accident and  
9 sickness coverage of additional newborn children or  
10 maternity benefits, may be issued in this state if it  
11 contains any provisions excluding or limiting initial  
12 coverage of a newborn infant for a period of time, or  
13 limitations or exclusions for congenital defects of a  
14 newborn child.

15 Revisor's Note

16 Section (E), V.T.I.C. Article 3.70-2, refers to a  
17 "newborn infant." For consistency throughout this  
18 subchapter, the revised law substitutes "newborn  
19 child" for "newborn infant."

20 [Sections 1367.004-1367.050 reserved for expansion]

21 SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

22 Revised Law

23 Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This  
24 subchapter applies only to a health benefit plan that:

25 (1) provides benefits for medical or surgical expenses  
26 incurred as a result of a health condition, accident, or sickness,  
27 including an individual, group, blanket, or franchise insurance  
28 policy or insurance agreement, a group hospital service contract,  
29 or an individual or group evidence of coverage that is offered by:

30 (A) an insurance company;

31 (B) a group hospital service corporation  
32 operating under Chapter 842;

33 (C) a fraternal benefit society operating under  
34 Chapter 885;

35 (D) a stipulated premium company operating under  
36 Chapter 884;

37 (E) a health maintenance organization operating  
38 under Chapter 843; or



1 (F) a multiple employer welfare arrangement  
2 subject to regulation under Chapter 846;

3 (2) is offered by an approved nonprofit health  
4 corporation that holds a certificate of authority under Chapter  
5 844; or

6 (3) provides health and accident coverage through a  
7 risk pool created under Chapter 172, Local Government Code,  
8 notwithstanding Section 172.014, Local Government Code, or any  
9 other law. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), as added Acts  
10 75th Leg., R.S., Ch. 683.)

11 Source Law

12 Sec. 2. (a) This article applies only to a  
13 health benefit plan that:

14 (1) provides benefits for medical or  
15 surgical expenses incurred as a result of a health  
16 condition, accident, or sickness, including an  
17 individual, group, blanket, or franchise insurance  
18 policy or insurance agreement, a group hospital  
19 service contract, or an individual or group evidence  
20 of coverage that is offered by:

21 (A) an insurance company;  
22 (B) a group hospital service  
23 corporation operating under Chapter 20 of this code;

24 (C) a fraternal benefit society  
25 operating under Chapter 10 of this code;

26 (D) a stipulated premium insurance  
27 company operating under Chapter 22 of this code;

28 (E) a health maintenance  
29 organization operating under the Texas Health  
30 Maintenance Organization Act (Chapter 20A, Vernon's  
31 Texas Insurance Code); or

32 (F) a multiple employer welfare  
33 arrangement subject to regulation under Subchapter I,  
34 Chapter 3 of this code; or

35 (2) is offered by an approved nonprofit  
36 health corporation that is certified under Section  
37 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
38 Texas Civil Statutes), and that holds a certificate of  
39 authority issued by the commissioner under Article  
40 21.52F of this code.

41 (c) Notwithstanding Section 172.014, Local  
42 Government Code, or any other law, this article  
43 applies to health and accident coverage provided by a  
44 risk pool created under Chapter 172, Local Government  
45 Code.

46 Revisor's Note

47 Section 2(a)(2), V.T.I.C. Article 21.53F, as  
48 added by Chapter 683, Acts of the 75th Legislature,  
49 Regular Session, 1997, refers to an approved nonprofit  
50 health corporation that is "certified under Section

5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

## Revised Law

Sec. 1367.052. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

1           (4) a workers' compensation insurance policy;  
2           (5) medical payment insurance coverage provided under  
3 a motor vehicle insurance policy; or  
4           (6) a long-term care insurance policy, including a  
5 nursing home fixed indemnity policy, unless the commissioner  
6 determines that the policy provides benefit coverage so  
7 comprehensive that the policy is a health benefit plan as described  
8 by Section 1367.051. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added  
9 Acts 75th Leg., R.S., Ch. 683.)

10                           Source Law

11           (b) This article does not apply to:  
12               (1) a plan that provides coverage:  
13                   (A) only for a specified disease or  
14 other limited benefit;  
15                   (B) only for accidental death or  
16 dismemberment;  
17                   (C) for wages or payments in lieu of  
18 wages for a period during which an employee is absent  
19 from work because of sickness or injury;  
20                   (D) as a supplement to liability  
21 insurance;  
22                   (E) for credit insurance;  
23                   (F) only for dental or vision care;  
24 or  
25                   (G) only for indemnity for hospital  
26 confinement;  
27               (2) a small employer health benefit plan  
28 written under Chapter 26 of this code;  
29               (3) a Medicare supplemental policy as  
30 defined by Section 1882(g)(1), Social Security Act (42  
31 U.S.C. Section 1395ss);  
32               (4) workers' compensation insurance  
33 coverage;  
34               (5) medical payment insurance issued as  
35 part of a motor vehicle insurance policy; or  
36               (6) a long-term care policy, including a  
37 nursing home fixed indemnity policy, unless the  
38 commissioner determines that the policy provides  
39 benefit coverage so comprehensive that the policy is a  
40 health benefit plan as described by Subsection (a) of  
41 this section.

42                           Revised Law

43           Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit  
44 plan that provides coverage for a family member of an insured or  
45 enrollee shall provide for each covered child from birth through  
46 the date of the child's sixth birthday coverage for:

- 47           (1) immunization against:  
48               (A) diphtheria;  
49               (B) haemophilus influenzae type b;

- (C) hepatitis B;
- (D) measles;
- (E) mumps;
- (F) pertussis;
- (G) polio;
- (H) rubella;
- (I) tetanus; and
- (J) varicella; and

(2) any other immunization that is required for the child by law.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for immunization against rotovirus. (V.T.I.C. Art. 20A.09F; Art. 21.53F, Secs. 3, 5, as added Acts 75th Leg., R.S., Ch. 683.)

#### Source Law

Art. 20A.09F. In addition to an immunization required under Section 3(a), Article 21.53F, Insurance Code, each health maintenance organization shall include in each health care plan provided by the organization coverage for immunization against rotovirus and any other immunization required for a child by statute or rule.

[Art. 21.53F]

Sec. 3. A health benefit plan that provides benefits for a family member of the insured shall provide coverage for each covered child described by Section 5 of this article, from birth through the date the child is six years of age, for:

- (1) immunization against:
  - (A) diphtheria;
  - (B) haemophilus influenzae type b;
  - (C) hepatitis B;
  - (D) measles;
  - (E) mumps;
  - (F) pertussis;
  - (G) polio;
  - (H) rubella;
  - (I) tetanus; and
  - (J) varicella; and

1                   (2) any other immunization that is  
2 required by law for the child.

3                   Sec. 5. A child is entitled to benefits under  
4 this article if the child, as a result of the child's  
5 relationship to an enrollee in the health benefit  
6 plan, would be entitled to benefits under an accident  
7 and sickness insurance policy under Subsection (K),  
8 (L), or (M), Section 2, Chapter 397, Acts of the 54th  
9 Legislature, 1955 (Article 3.70-2, Vernon's Texas  
10 Insurance Code).

11                   Revisor's Note

12                   (1) V.T.I.C. Article 20A.09F requires a health  
13 maintenance organization to provide coverage for any  
14 immunization required for a child by "statute or  
15 rule." The revised law substitutes "law" for "statute  
16 or rule" because in context "law" is synonymous with  
17 "statute or rule" and "law" is the more commonly used  
18 term.

19                   (2) Section 3, V.T.I.C. Article 21.53F, as added  
20 by Chapter 683, Acts of the 75th Legislature, Regular  
21 Session, 1997, refers to coverage for a family member  
22 of the "insured." "Insured" is a term used in  
23 conjunction with traditional insurance. This  
24 subchapter also applies to health benefit plans  
25 offered by entities such as health maintenance  
26 organizations that are not insurers. In relation to  
27 those plans, "enrollee" is a more accurate term than  
28 "insured," and the revised law consequently adds a  
29 reference to "enrollee."

30                   Revised Law

31                   Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE  
32 REQUIREMENT PROHIBITED. (a) Coverage required under Section  
33 1367.053(a) may not be made subject to a deductible, copayment, or  
34 coinsurance requirement.

35                   (b) This section does not prohibit the application of a  
36 deductible, copayment, or coinsurance requirement to another  
37 service provided at the same time the immunization is administered.  
38 (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S.,

Ch. 683.)

Source Law

Sec. 6. (a) Benefits required under Section 3 of this article may not be made subject to a deductible, copayment, or coinsurance requirement. This subsection does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time as the immunization.

Revised Law

Sec. 1367.055. RULES. The commissioner may adopt reasonable rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Sec. 7, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Sec. 7. The commissioner may adopt rules as necessary to implement this article.

[Sections 1367.056-1367.100 reserved for expansion]

SUBCHAPTER C. HEARING TEST

Revised Law

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

1           (2) is offered by an approved nonprofit health  
2 corporation that holds a certificate of authority under Chapter  
3 844; or

4           (3) provides health and accident coverage through a  
5 risk pool created under Chapter 172, Local Government Code,  
6 notwithstanding Section 172.014, Local Government Code, or any  
7 other law.

8           (b) This subchapter applies to a health benefit plan  
9 described by Subsection (a) that provides coverage to a resident of  
10 this state, regardless of whether the plan issuer is located in or  
11 outside this state. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), 4(c)  
12 (part), as added Acts 75th Leg., R.S., Ch. 683.)

13                               Source Law

14           Sec. 2. (a) This article applies only to a  
15 health benefit plan that:

16                       (1) provides benefits for medical or  
17 surgical expenses incurred as a result of a health  
18 condition, accident, or sickness, including an  
19 individual, group, blanket, or franchise insurance  
20 policy or insurance agreement, a group hospital  
21 service contract, or an individual or group evidence  
22 of coverage that is offered by:

- 23                               (A) an insurance company;  
24                               (B) a group hospital service  
25 corporation operating under Chapter 20 of this code;  
26                               (C) a fraternal benefit society  
27 operating under Chapter 10 of this code;  
28                               (D) a stipulated premium insurance  
29 company operating under Chapter 22 of this code;  
30                               (E) a health maintenance  
31 organization operating under the Texas Health  
32 Maintenance Organization Act (Chapter 20A, Vernon's  
33 Texas Insurance Code); or  
34                               (F) a multiple employer welfare  
35 arrangement subject to regulation under Subchapter I,  
36 Chapter 3 of this code; or

37                       (2) is offered by an approved nonprofit  
38 health corporation that is certified under Section  
39 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
40 Texas Civil Statutes), and that holds a certificate of  
41 authority issued by the commissioner under Article  
42 21.52F of this code.

43           (c) Notwithstanding Section 172.014, Local  
44 Government Code, or any other law, this article  
45 applies to health and accident coverage provided by a  
46 risk pool created under Chapter 172, Local Government  
47 Code.

48           [Sec. 4]

49           (c) This section applies to any health benefit  
50 plan that provides coverage or benefits to a resident  
51 of this state, without regard to whether the issuer of  
52 the health benefit plan is located within or outside

1           this state. . . .

2                               Revisor's Note

3           Section 2(a), V.T.I.C. Article 21.53F, as added  
4           by Chapter 683, Acts of the 75th Legislature, Regular  
5           Session, 1997, refers to an approved nonprofit health  
6           corporation that is "certified under Section 5.01(a),  
7           Medical Practice Act," and holds a certificate of  
8           authority "issued by the commissioner under Article  
9           21.52F." The revised law omits the reference to  
10          certification under Section 5.01(a), Medical Practice  
11          Act, and the reference to the commissioner issuing the  
12          certificate of authority for the reasons stated in the  
13          revisor's note to Section 1367.051.

14                              Revised Law

15          Sec. 1367.102. EXCEPTION. This subchapter does not apply  
16          to:

17                  (1) a plan that provides coverage:

18                          (A) only for a specified disease or for another  
19          limited benefit;

20                          (B) only for accidental death or dismemberment;

21                          (C) for wages or payments in lieu of wages for a  
22          period during which an employee is absent from work because of  
23          sickness or injury;

24                          (D) as a supplement to a liability insurance  
25          policy;

26                          (E) for credit insurance;

27                          (F) only for dental or vision care; or

28                          (G) only for indemnity for hospital confinement;

29                  (2) a small employer health benefit plan written under  
30          Chapter 1501;

31                  (3) a Medicare supplemental policy as defined by  
32          Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

33                  (4) a workers' compensation insurance policy;

34                  (5) medical payment insurance coverage provided under



1 a motor vehicle insurance policy; or

2 (6) a long-term care insurance policy, including a  
3 nursing home fixed indemnity policy, unless the commissioner  
4 determines that the policy provides benefit coverage so  
5 comprehensive that the policy is a health benefit plan as described  
6 by Section 1367.101. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added  
7 Acts 75th Leg., R.S., Ch. 683.)

8 Source Law

9 (b) This article does not apply to:

10 (1) a plan that provides coverage:

11 (A) only for a specified disease or  
12 other limited benefit;

13 (B) only for accidental death or  
14 dismemberment;

15 (C) for wages or payments in lieu of  
16 wages for a period during which an employee is absent  
17 from work because of sickness or injury;

18 (D) as a supplement to liability  
19 insurance;

20 (E) for credit insurance;

21 (F) only for dental or vision care;

22 or

23 (G) only for indemnity for hospital  
24 confinement;

25 (2) a small employer health benefit plan  
26 written under Chapter 26 of this code;

27 (3) a Medicare supplemental policy as  
28 defined by Section 1882(g)(1), Social Security Act (42  
29 U.S.C. Section 1395ss);

30 (4) workers' compensation insurance  
31 coverage;

32 (5) medical payment insurance issued as  
33 part of a motor vehicle insurance policy; or

34 (6) a long-term care policy, including a  
35 nursing home fixed indemnity policy, unless the  
36 commissioner determines that the policy provides  
37 benefit coverage so comprehensive that the policy is a  
38 health benefit plan as described by Subsection (a) of  
39 this section.

40 Revised Law

41 Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit  
42 plan that provides coverage for a family member of an insured or  
43 enrollee shall provide to each covered child coverage for:

44 (1) a screening test for hearing loss from birth  
45 through the date the child is 30 days of age, as provided by Chapter  
46 47, Health and Safety Code; and

47 (2) necessary diagnostic follow-up care related to the  
48 screening test from birth through the date the child is 24 months of  
49 age.

1 (b) For purposes of Subsection (a), a covered child is a  
2 child who, as a result of the child's relationship to an insured or  
3 enrollee in a health benefit plan, would be entitled to coverage  
4 under an accident and health insurance policy under Section  
5 1201.061, 1201.062, 1201.063, or 1201.064.

6 (c) This section does not require a health benefit plan to  
7 provide the coverage described by this section to a child of an  
8 individual residing in this state if the individual is:

9 (1) employed outside this state; and

10 (2) covered under a health benefit plan maintained for  
11 the individual by the individual's employer as an employment  
12 benefit. (V.T.I.C. Art. 21.53F, Secs. 4(a), (c) (part), 5, as  
13 added Acts 75th Leg., R.S., Ch. 683.)

14 Source Law

15 Sec. 4. (a) A health benefit plan that  
16 provides benefits for a family member of the insured  
17 shall provide coverage for each covered child  
18 described by Section 5 of this article for:

19 (1) a screening test for hearing loss from  
20 birth through the date the child is 30 days old, as  
21 provided by Chapter 47, Health and Safety Code; and

22 (2) necessary diagnostic follow-up care  
23 related to the screening test from birth through the  
24 date the child is 24 months old.

25 (c) . . . This section does not require the  
26 issuer of a health benefit plan to provide coverage  
27 under this section for the child of a resident of this  
28 state who:

29 (1) is employed outside of this state; and

30 (2) is covered under a health benefit plan  
31 maintained for the individual by the individual's  
32 employer as an employment benefit.

33 Sec. 5. A child is entitled to benefits under  
34 this article if the child, as a result of the child's  
35 relationship to an enrollee in the health benefit  
36 plan, would be entitled to benefits under an accident  
37 and sickness insurance policy under Subsection (K),  
38 (L), or (M), Section 2, Chapter 397, Acts of the 54th  
39 Legislature, 1955 (Article 3.70-2, Vernon's Texas  
40 Insurance Code).

41 Revisor's Note

42 Section 4(a), V.T.I.C. Article 21.53F, as added  
43 by Chapter 683, Acts of the 75th Legislature, Regular  
44 Session, 1997, refers to coverage for a family member  
45 of the "insured." The revised law adds a reference to

"enrollee" for the reason stated in Revisor's Note (2)  
to Section 1367.053.

Revised Law

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT  
PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED;  
NOTICE REQUIRED. (a) Coverage required under this subchapter:

(1) may be subject to a copayment or coinsurance  
requirement; and

(2) may not be subject to a deductible requirement or a  
dollar limit.

(b) The requirements of this section must be stated in the  
coverage document. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts  
75th Leg., R.S., Ch. 683.)

Source Law

(b) Benefits required under Section 4 of this  
article may be subject to copayment and coinsurance  
requirements, but may not be subject to a deductible  
requirement or dollar limit. The requirements of this  
subsection must be stated in the coverage document.

Revised Law

Sec. 1367.105. RULES. The commissioner may adopt rules  
necessary to implement this subchapter. (V.T.I.C. Art. 21.53F,  
Secs. 4(b), 7, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

[Sec. 4]  
(b) The commissioner may adopt rules to  
implement the requirement of this section.

Sec. 7. The commissioner may adopt rules as  
necessary to implement this article.

[Sections 1367.106-1367.150 reserved for expansion]

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Revised Law

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This  
subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses  
incurred as a result of a health condition, accident, or sickness,  
including:

1 (A) an individual, group, blanket, or franchise  
2 insurance policy or insurance agreement, a group hospital service  
3 contract, or an individual or group evidence of coverage that is  
4 offered by:

5 (i) an insurance company;  
6 (ii) a group hospital service corporation  
7 operating under Chapter 842;

8 (iii) a fraternal benefit society operating  
9 under Chapter 885;

10 (iv) a stipulated premium company operating  
11 under Chapter 884; or

12 (v) a health maintenance organization  
13 operating under Chapter 843; and

14 (B) to the extent permitted by the Employee  
15 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et  
16 seq.), a health benefit plan that is offered by:

17 (i) a multiple employer welfare arrangement  
18 as defined by Section 3 of that Act;

19 (ii) an entity not authorized under this  
20 code or another insurance law of this state that contracts directly  
21 for health care services on a risk-sharing basis, including a  
22 capitation basis; or

23 (iii) another analogous benefit  
24 arrangement; or

25 (2) is offered by an approved nonprofit health  
26 corporation that holds a certificate of authority under Chapter  
27 844. (V.T.I.C. Art. 21.53W, Sec. 2(a).)

28 Source Law

29 Sec. 2. (a) This article applies only to a  
30 health benefit plan that:

31 (1) provides benefits for medical or  
32 surgical expenses incurred as a result of a health  
33 condition, accident, or sickness, including:

34 (A) an individual, group, blanket, or  
35 franchise insurance policy or insurance agreement, a  
36 group hospital service contract, or an individual or  
37 group evidence of coverage that is offered by:

38 (i) an insurance company;  
39 (ii) a group hospital service

corporation operating under Chapter 20 of this code;  
 (iii) a fraternal benefit  
 society operating under Chapter 10 of this code;  
 (iv) a stipulated premium  
 insurance company operating under Chapter 22 of this  
 code; or  
 (v) a health maintenance  
 organization operating under the Texas Health  
 Maintenance Organization Act (Chapter 20A, Vernon's  
 Texas Insurance Code); or  
 (B) to the extent permitted by the  
 Employee Retirement Income Security Act of 1974 (29  
 U.S.C. Section 1001 et seq.), a health benefit plan  
 that is offered by:  
 (i) a multiple employer welfare  
 arrangement as defined by Section 3, Employee  
 Retirement Income Security Act of 1974 (29 U.S.C.  
 Section 1002);  
 (ii) any other entity not  
 licensed under this code or another insurance law of  
 this state that contracts directly for health care  
 services on a risk-sharing basis, including an entity  
 that contracts for health care services on a  
 capitation basis; or  
 (iii) another analogous benefit  
 arrangement; or  
 (2) is offered by an approved nonprofit  
 health corporation that is certified under Section  
 5.01(a), Medical Practice Act (Article 4495b, Vernon's  
 Texas Civil Statutes), and that holds a certificate of  
 authority issued by the commissioner under Article  
 21.52F of this code.

#### Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53W,  
 refers to a health benefit plan offered by an entity  
 that is not "licensed" under the Insurance Code or  
 another insurance law of this state. The revised law  
 substitutes "authorized" for "licensed" for  
 consistency with terminology used throughout this  
 code.

(2) Section 2(a), V.T.I.C. Article 21.53W,  
 refers to an approved nonprofit health corporation  
 that is "certified under Section 5.01(a), Medical  
 Practice Act," and holds a certificate of authority  
 "issued by the commissioner under Article 21.52F."  
 The revised law omits the reference to certification  
 under Section 5.01(a), Medical Practice Act, and the  
 reference to the commissioner issuing the certificate  
 of authority for the reasons stated in the revisor's  
 note to Section 1367.051.



1 (D) as a supplement to liability  
2 insurance;  
3 (E) for credit insurance;  
4 (F) only for dental or vision care;  
5 or  
6 (G) only for indemnity for hospital  
7 confinement or other hospital expenses;  
8 (2) a small employer health benefit plan  
9 written under Chapter 26 of this code;  
10 (3) a Medicare supplemental policy as  
11 defined by Section 1882(g)(1), Social Security Act (42  
12 U.S.C. Section 1395ss);  
13 (4) workers' compensation insurance  
14 coverage;  
15 (5) medical payment insurance issued as  
16 part of a motor vehicle insurance policy; or  
17 (6) a long-term care policy, including a  
18 nursing home fixed indemnity policy, unless the  
19 commissioner determines that the policy provides  
20 benefit coverage so comprehensive that the policy is a  
21 health benefit plan as described by Subsection (a) of  
22 this section.

23 Revised Law

24 Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL  
25 ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that  
26 provides coverage for a child who is younger than 18 years of age  
27 must define "reconstructive surgery for craniofacial  
28 abnormalities" under the plan to mean surgery to improve the  
29 function of, or to attempt to create a normal appearance of, an  
30 abnormal structure caused by congenital defects, developmental  
31 deformities, trauma, tumors, infections, or disease. (V.T.I.C.  
32 Art. 21.53W, Sec. 3.)

33 Source Law

34 Sec. 3. A health benefit plan that provides  
35 benefits to a child who is younger than 18 years of age  
36 must define reconstructive surgery for craniofacial  
37 abnormalities under the plan to mean surgery to  
38 improve the function of, or to attempt to create a  
39 normal appearance of, an abnormal structure caused by  
40 congenital defects, developmental deformities,  
41 trauma, tumors, infections, or disease.

42 Revised Law

43 Sec. 1367.154. RULES. The commissioner shall adopt rules  
44 necessary to administer this subchapter. (V.T.I.C. Art. 21.53W,  
45 Sec. 4.)

46 Source Law

47 Sec. 4. The commissioner shall adopt rules as  
48 necessary to administer this article.

1                                    Revisor's Note  
2                                    (End of Subchapter)

3                    (1) Section 1(1), V.T.I.C. Article 21.53W,  
4 defines "enrollee." The revised law omits the  
5 definition as unnecessary because the defined term is  
6 not used in the revision of Article 21.53W. The  
7 omitted law reads:

8                                    Art. 21.53W  
9                                    Sec. 1. In this article:  
10                                    (1) "Enrollee" means an  
11 individual enrolled in a health benefit  
12 plan.

13                    (2) Section 1(2), V.T.I.C. Article 21.53W,  
14 defines "health benefit plan." The revised law omits  
15 the definition as unnecessary because Section 2 of  
16 that article, revised as Sections 1367.151 and  
17 1367.152, specifies the types of health benefit plans  
18 to which this subchapter applies, and thus the defined  
19 term is not helpful to the reader. The omitted law  
20 reads:

21                                    (2) "Health benefit plan" means  
22 a plan described by Section 2(a) of this  
23 article.

24                                    Revisor's Note  
25                                    (End of Chapter)

26                    Section 1, V.T.I.C. Article 21.53F, as added by  
27 Chapter 683, Acts of the 75th Legislature, Regular  
28 Session, 1997, defines "health benefit plan." The  
29 revised law omits the definition as unnecessary  
30 because Section 2 of that article, revised as Sections  
31 1367.051, 1367.052, 1367.101, and 1367.102, specify  
32 the types of health benefit plans to which Subchapters  
33 B and C apply, and thus the defined term is not helpful  
34 to the reader. The omitted law reads:

35                                    Art. 21.53F  
36                                    Sec. 1. In this article, "health  
37 benefit plan" means a plan described by  
38 Section 2 of this article.



1 CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

2 Sec. 1368.001. DEFINITIONS . . . . . 1025

3 Sec. 1368.002. APPLICABILITY OF CHAPTER . . . . . 1027

4 Sec. 1368.003. EXCEPTION. . . . . 1028

5 Sec. 1368.004. COVERAGE REQUIRED . . . . . 1031

6 Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS . . . . . 1031

7 Sec. 1368.006. LIMITATION ON COVERAGE . . . . . 1033

8 Sec. 1368.007. TREATMENT STANDARDS . . . . . 1033

9 Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY

10 WITH CHAPTER . . . . . 1035

11 CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

12 Revised Law

13 Sec. 1368.001. DEFINITIONS. In this chapter:

14 (1) "Chemical dependency" means the abuse of, a

15 psychological or physical dependence on, or an addiction to alcohol

16 or a controlled substance.

17 (2) "Chemical dependency treatment center" means a

18 facility that provides a program for the treatment of chemical

19 dependency under a written treatment plan approved and monitored by

20 a physician and that is:

21 (A) affiliated with a hospital under a

22 contractual agreement with an established system for patient

23 referral;

24 (B) accredited as a chemical dependency

25 treatment center by the Joint Commission on Accreditation of

26 Healthcare Organizations;

27 (C) licensed as a chemical dependency treatment

28 program by the Texas Commission on Alcohol and Drug Abuse; or

29 (D) licensed, certified, or approved as a

30 chemical dependency treatment program or center by another state

31 agency.

32 (3) "Controlled substance" means an abusable volatile

33 chemical, as defined by Section 485.001, Health and Safety Code, or

34 a substance designated as a controlled substance under Chapter 481,

1 Health and Safety Code. (V.T.I.C. Art. 3.51-9, Secs. 2, 2A(e).)

2 Source Law

3 Sec. 2. In this article:

4 (1) "Chemical dependency" means the abuse  
5 of or psychological or physical dependence on or  
6 addiction to alcohol or a controlled substance.

7 (2) "Controlled substance" means a toxic  
8 inhalant or a substance designated as a controlled  
9 substance in the Chapter 481, Health and Safety Code.

10 (3) "Toxic inhalant" means a volatile  
11 chemical under Chapter 484, Health and Safety Code, or  
12 abusable glue or aerosol paint under Section 485.001,  
13 Health and Safety Code.

14 [Sec. 2A]

15 (e) For purposes of this section, the term  
16 "chemical dependency treatment center" means a  
17 facility which provides a program for the treatment of  
18 chemical dependency pursuant to a written treatment  
19 plan approved and monitored by a physician and which  
20 facility is also:

21 (1) affiliated with a hospital under a  
22 contractual agreement with an established system for  
23 patient referral; or

24 (2) accredited as such a facility by the  
25 Joint Commission on Accreditation of Hospitals; or

26 (3) licensed as a chemical dependency  
27 treatment program by the Texas Commission on Alcohol  
28 and Drug Abuse; or

29 (4) licensed, certified, or approved as a  
30 chemical dependency treatment program or center by any  
31 other state agency having legal authority to so  
32 license, certify, or approve.

33 Revisor's Note

34 (1) Section 2(3), V.T.I.C. Article 3.51-9,  
35 defines "toxic inhalant" to mean a volatile chemical  
36 under Chapter 484, Health and Safety Code, or an  
37 abusable glue or aerosol paint under Section 485.001,  
38 Health and Safety Code. Chapter 459, Acts of the 77th  
39 Legislature, Regular Session, 2001, amended Section  
40 484.002, Health and Safety Code, which designates  
41 certain chemicals as volatile chemicals. However,  
42 Chapter 1463, Acts of the 77th Legislature, Regular  
43 Session, 2001, repealed Chapter 484, Health and  
44 Safety Code, and amended Section 485.001, Health and  
45 Safety Code, by substituting the term "abusable  
46 volatile chemical" for the defined term "abusable glue  
47 or aerosol paint." Section 311.025, Government Code  
48 (Code Construction Act), provides that "[i]f the

1 amendments [to the same statute enacted in the same  
2 session of the legislature] are irreconcilable, the  
3 latest in date of enactment prevails" and further  
4 provides a method for determining the latest in date of  
5 enactment. Under this method, Chapter 1463 prevails  
6 over Chapter 459. Consequently, the revised law  
7 substitutes "abusable volatile chemical as defined by  
8 Section 485.001, Health and Safety Code," for "toxic  
9 inhalant" and the definition of "toxic inhalant"  
10 provided by Section 2(3), V.T.I.C. Article 3.51-9. In  
11 addition, the revised law incorporates the substance  
12 of the definition of "abusable volatile chemical" into  
13 the definition of "controlled substance" provided by  
14 Section 2(2), V.T.I.C. Article 3.51-9, revised as  
15 Section 1368.001(3), because that is the only other  
16 use of the term "toxic inhalant," revised as "abusable  
17 volatile chemical," in V.T.I.C. Article 3.51-9.

18 (2) Section 2A(e)(2), V.T.I.C. Article 3.51-9,  
19 refers to the "Joint Commission on Accreditation of  
20 Hospitals." The proper name of that organization is  
21 the Joint Commission on Accreditation of Healthcare  
22 Organizations. The revised law is drafted  
23 accordingly.

24 (3) Section 2A(e)(4), V.T.I.C. Article 3.51-9,  
25 refers to a facility licensed, certified, or approved  
26 as a chemical dependency treatment program or center  
27 by a state agency "having legal authority to so  
28 license, certify, or approve." The revised law omits  
29 the quoted language as unnecessary because only an  
30 authorized agency may effectively license, certify, or  
31 approve a treatment program or center.

#### 32 Revised Law

33 Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter  
34 applies only to a group health benefit plan that provides hospital

1 and medical coverage or services on an expense incurred, service,  
2 or prepaid basis, including a group insurance policy or contract or  
3 self-funded or self-insured plan or arrangement that is offered in  
4 this state by:

5 (1) an insurer;

6 (2) a group hospital service corporation operating  
7 under Chapter 842;

8 (3) a health maintenance organization operating under  
9 Chapter 843; or

10 (4) an employer, trustee, or other self-funded or  
11 self-insured plan or arrangement. (V.T.I.C. Art. 3.51-9, Sec.  
12 2A(a) (part).)

13 Source Law

14 Sec. 2A. (a) Insurers, nonprofit hospital and  
15 medical service plan corporations subject to Chapter  
16 20 of this code, health maintenance organizations  
17 providing group health coverage, and all employer,  
18 trustee, or other self-funded or self-insured plans or  
19 arrangements transacting health insurance or  
20 providing other health coverage or services in this  
21 state . . . under such group insurance policies or  
22 contracts and such plans or arrangements providing  
23 hospital and medical coverage or services on an  
24 expense incurred, service, or prepaid basis . . . .

25 Revisor's Note

26 Section 2A(a), V.T.I.C. Article 3.51-9, refers to  
27 "nonprofit hospital and medical service plan  
28 corporations" subject to V.T.I.C. Chapter 20, revised  
29 as Chapter 842 of this code. The term most frequently  
30 used to describe such a corporation is "group hospital  
31 service corporation." Consequently, the revised law  
32 substitutes "group hospital service corporation" for  
33 "nonprofit hospital and medical service plan  
34 corporations" to provide for consistent use of  
35 terminology throughout this code.

36 Revised Law

37 Sec. 1368.003. EXCEPTION. This chapter does not apply to:

38 (1) an employer, trustee, or other self-funded or  
39 self-insured plan or arrangement with 250 or fewer employees or

1 members;

2 (2) an individual insurance policy;

3 (3) an individual evidence of coverage issued by a  
4 health maintenance organization;

5 (4) a health insurance policy that provides only:

6 (A) cash indemnity for hospital or other  
7 confinement benefits;

8 (B) supplemental or limited benefit coverage;

9 (C) coverage for specified diseases or  
10 accidents;

11 (D) disability income coverage; or

12 (E) any combination of those benefits or  
13 coverages;

14 (5) a blanket insurance policy;

15 (6) a short-term travel insurance policy;

16 (7) an accident-only insurance policy;

17 (8) a limited or specified disease insurance policy;

18 (9) an individual conversion insurance policy or  
19 contract;

20 (10) a policy or contract designed for issuance to a  
21 person eligible for Medicare coverage or other similar coverage  
22 under a state or federal government plan; or

23 (11) an evidence of coverage provided by a health  
24 maintenance organization if the plan holder is the subject of a  
25 collective bargaining agreement that was in effect on January 1,  
26 1982, and that has not expired since that date. (V.T.I.C.  
27 Art. 3.51-9, Secs. 2A(c), 3 (part).)

28 Source Law

29 [Sec. 2A]

30 (c) This section does not apply to any employer,  
31 trustee, or any other self-funded or self-insured  
32 plans or arrangements with 250 or fewer employees or  
33 members, or any individual insurance policies  
34 regardless of the method of solicitation or sale, or  
35 any individual H.M.O. policies, or to any health  
36 insurance policies that only provide cash indemnity  
37 for hospital or other confinement benefits, or  
38 supplemental or limited benefit coverage, or coverage  
39 for specified diseases or accidents, or disability

1 income coverage, or any combination thereof.

2 Sec. 3. This Act applies to group policies or  
3 contracts or coverage provided by health maintenance  
4 organizations delivered or issued for delivery or  
5 renewed, extended, or amended in this state on or after  
6 January 1, 1982, or upon the expiration of a collective  
7 bargaining agreement applicable to a particular  
8 policyholder, whichever is later; provided that this  
9 Act does not apply to blanket, short-term travel,  
10 accident only, limited or specified disease,  
11 individual conversion policies or contracts, nor to  
12 policies or contracts designed for issuance to persons  
13 eligible for coverage under Title XVIII of the Social  
14 Security Act, known as Medicare, or any other similar  
15 coverage under state or federal governmental  
16 plans. . . .

17 Revisor's Note

18 (1) Section 2A(c), V.T.I.C. Article 3.51-9,  
19 provides that the section does not apply to "any  
20 individual insurance policies regardless of the method  
21 of solicitation or sale." The revised law omits  
22 "regardless of the method of solicitation or sale"  
23 because, in context, it is unnecessary and does not add  
24 to the clear meaning of the law. A policy is either an  
25 individual policy or it is not, and the method of  
26 solicitation or sale is irrelevant to that  
27 determination.

28 (2) Section 2A(c), V.T.I.C. Article 3.51-9,  
29 refers to health maintenance organization "policies."  
30 The term most frequently used to describe the type of  
31 coverage document issued by a health maintenance  
32 organization is "evidence of coverage." Consequently,  
33 the revised law substitutes "evidence of coverage" for  
34 "policies" to provide for consistent use of  
35 terminology throughout this code. Comparable changes  
36 have been made throughout this chapter.

37 (3) Section 3, V.T.I.C. Article 3.51-9,  
38 provides that the article applies to "group policies  
39 or contracts or coverage provided by health  
40 maintenance organizations delivered or issued for  
41 delivery or renewed, extended, or amended in this

1 state on or after January 1, 1982." The revised law  
2 omits the provision as obsolete; any policy or  
3 contract now in effect would have been delivered,  
4 issued, renewed, extended, or amended on or after  
5 January 1, 1982.

6 (4) Section 3, V.T.I.C. Article 3.51-9, refers  
7 to "Title XVIII of the Social Security Act, known as  
8 Medicare." The revised law omits the reference to  
9 "Title XVIII of the Social Security Act" as  
10 unnecessary because "Medicare" is commonly used in  
11 other statutes of the state without an accompanying  
12 citation, and its meaning is unambiguous.

#### 13 Revised Law

14 Sec. 1368.004. COVERAGE REQUIRED. (a) A group health  
15 benefit plan shall provide coverage for the necessary care and  
16 treatment of chemical dependency.

17 (b) Coverage required under this section may be provided:

18 (1) directly by the group health benefit plan issuer;  
19 or

20 (2) by another entity, including a single service  
21 health maintenance organization, under contract with the group  
22 health benefit plan issuer. (V.T.I.C. Art. 3.51-9, Sec. 2A(a)  
23 (part).)

#### 24 Source Law

25 (a) [Insurers, nonprofit hospital and medical  
26 service plan corporations subject to Chapter 20 of  
27 this code, health maintenance organizations providing  
28 group health coverage, and all employer, trustee, or  
29 other self-funded or self-insured plans or  
30 arrangements transacting health insurance or  
31 providing other health coverage or services in this  
32 state] shall provide, directly or by contract with  
33 other entities, including a single service health  
34 maintenance organization, . . . benefits for the  
35 necessary care and treatment of chemical  
36 dependency . . . .

#### 37 Revised Law

38 Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except  
39 as provided by Subsection (b), coverage required under this

chapter:

(1) may not be less favorable than coverage provided for physical illness generally under the plan; and

(2) shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors that apply to coverage provided for physical illness generally under the plan.

(b) A group health benefit plan may set dollar or durational limits for coverage required under this chapter that are less favorable than for coverage provided for physical illness generally under the plan if those limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Section 1368.007. If guidelines and standards adopted under Section 1368.007 are not in effect, the dollar and durational limits may not be less favorable than for physical illness generally.

(c) This section does not require payment of a usual, customary, and reasonable rate for treatment of a covered individual if a health maintenance organization or preferred provider organization establishes a negotiated rate for the locality in which the covered individual customarily receives care. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

#### Source Law

(a) [Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state shall provide] . . . benefits for the necessary care and treatment of chemical dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors. An entity under this section may set dollar or durational limits in a policy, contract, plan, or arrangement providing benefits under this article which are less favorable than for physical illness generally if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Subsection (d) of this section.

This section shall not be construed to require that a usual, customary, and reasonable rate be paid when a negotiated rate is established by a health maintenance organization or preferred provider



1 organization for the locality in which the covered  
2 individual customarily receives care.

3 If no guidelines or standards are in effect under  
4 Subsection (d), such limits shall be no less favorable  
5 than for physical illness generally.

6 Revised Law

7 Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this  
8 section, "treatment series" means a planned, structured, and  
9 organized program to promote chemical-free status that:

10 (1) may include different facilities or modalities;  
11 and

12 (2) is completed when the covered individual:

13 (A) is, on medical advice, discharged from:

14 (i) inpatient detoxification;

15 (ii) inpatient rehabilitation or  
16 treatment;

17 (iii) partial hospitalization or intensive  
18 outpatient treatment; or

19 (iv) a series of those levels of treatments  
20 without a lapse in treatment; or

21 (B) fails to materially comply with the treatment  
22 program for a period of 30 days.

23 (b) Notwithstanding Section 1368.005, coverage required  
24 under this chapter is limited to a lifetime maximum of three  
25 separate treatment series for each covered individual. (V.T.I.C.  
26 Art. 3.51-9, Sec. 2A(b).)

27 Source Law

28 (b) Notwithstanding Subsection (a) of this  
29 section, coverage for chemical dependency is limited  
30 to a lifetime maximum of three separate series of  
31 treatments for each covered individual.

32 A series of treatments is a planned, structured,  
33 and organized program to promote chemical free status  
34 which may include different facilities or modalities  
35 and is complete when the covered individual is  
36 discharged on medical advice from inpatient  
37 detoxification, inpatient rehabilitation/treatment,  
38 partial hospitalization or intensive outpatient or a  
39 series of these levels of treatments without a lapse in  
40 treatment or when a person fails to materially comply  
41 with the treatment program for a period of 30 days.

42 Revised Law

43 Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided

1 under this chapter for necessary care and treatment in a chemical  
2 dependency treatment center must be provided as if the care and  
3 treatment were provided in a hospital.

4 (b) The department by rule shall adopt standards formulated  
5 and approved by the department and the Texas Commission on Alcohol  
6 and Drug Abuse for use by insurers, other third-party reimbursement  
7 sources, and chemical dependency treatment centers.

8 (c) Standards adopted under this section must provide for:

9 (1) reasonable control of costs necessary for  
10 inpatient and outpatient treatment of chemical dependency,  
11 including guidelines for treatment periods; and

12 (2) appropriate utilization review of treatment as  
13 well as necessary extensions of treatment.

14 (d) Coverage required under this chapter is subject to the  
15 standards adopted under this section. (V.T.I.C. Art. 3.51-9, Sec.  
16 2A(d).)

17 Source Law

18 (d) Any benefits so provided shall be determined  
19 as if necessary care and treatment in a chemical  
20 dependency treatment center were care and treatment in  
21 a hospital. The Texas Department of Insurance and the  
22 Texas Commission on Alcohol and Drug Abuse shall  
23 formulate standards for use by insurers, other third  
24 party reimbursement sources, and chemical dependency  
25 treatment centers for the reasonable control of costs  
26 necessary for inpatient and outpatient treatment of  
27 chemical dependency, including guidelines for  
28 treatment periods. The standards shall provide for  
29 appropriate utilization review of treatment as well as  
30 necessary extensions of treatment. The department by  
31 rule shall adopt the standards as approved by both the  
32 department and the Texas Commission on Alcohol and  
33 Drug Abuse, and those standards are applicable to the  
34 provision of all services under this section. On  
35 adoption of standards or rules by the department under  
36 this section, benefits provided herein shall be  
37 subject to those standards or rules.

38 Revisor's Note

39 Section 2A(d), V.T.I.C. Article 3.51-9, provides  
40 that the "services" and "benefits" provided under that  
41 section are subject to certain standards adopted by  
42 the Texas Department of Insurance. The revised law  
43 substitutes "coverage" for "services" and "benefits"

1 to provide for consistent use of terminology  
2 throughout this chapter.

3 Revised Law

4 Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH  
5 CHAPTER. A group health benefit plan issuer that uses a policy  
6 form approved by the commissioner before November 10, 1981, may use  
7 an endorsement or rider to comply with this chapter if the  
8 endorsement or rider is approved by the commissioner as complying  
9 with this chapter and other provisions of this code. (V.T.I.C.  
10 Art. 3.51-9, Sec. 3 (part).)

11 Source Law

12 Sec. 3. . . . With respect to any policy forms  
13 approved by the State Board of Insurance prior to the  
14 effective date of this Act, an insurer is authorized to  
15 achieve compliance with this Act by the use of  
16 endorsements or riders provided such endorsements or  
17 riders are approved by the State Board of Insurance as  
18 being in compliance with this Act and other provisions  
19 of the Texas Insurance Code.

20 Revisor's Note

21 (1) Section 3, V.T.I.C. Article 3.51-9, refers  
22 to the "State Board of Insurance." Chapter 685, Acts  
23 of the 73rd Legislature, Regular Session, 1993,  
24 abolished the State Board of Insurance and transferred  
25 its functions to the commissioner of insurance and the  
26 Texas Department of Insurance. The reference to the  
27 State Board of Insurance has been changed  
28 appropriately.

29 (2) Section 3, V.T.I.C. Article 3.51-9, refers  
30 to an "insurer." The revised law substitutes "group  
31 health benefit plan issuer" for "insurer" to provide  
32 for consistent use of terminology throughout this  
33 chapter.

34 (3) Section 3, V.T.I.C. Article 3.51-9, refers  
35 to "the effective date of this Act." The effective  
36 date of the act that added that section is November 10,  
37 1981. Consequently, the revised law substitutes

"November 10, 1981," for the quoted language.

Revisor's Note  
(End of Chapter)

Section 1, V.T.I.C. Article 3.51-9, states the purpose of that article. The revised law omits the provision as unnecessary because it is nonsubstantive and because the legislative purpose in enacting the article is clear from the other, substantive provisions of the article revised in this chapter. The omitted law reads:

Art. 3.51-9

Sec. 1. The purpose of this article is to provide consumers with benefits for the care and treatment of chemical dependency in group health insurance policies or contracts, group health coverage provided by health maintenance organizations, and all self-funded or self-insured plans (but excluding those self-funded or self-insured plans with 250 or fewer employees or members), that provide basic hospital, surgical, or major medical expense benefits or coverages or any combination of these coverages, but excluding all individual insurance policies, and any individual H.M.O. policies, regardless of the method of solicitation or sale, and excluding all health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability income coverage, or any combination thereof.

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS  
AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

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